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Benevolent self-interest : a factor in social policy governing lunatics 1808-1862

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BENEVOLENT SELF-INTEREST:
A FACTOR IN SOCIAL POLICY GOVERNING LUNATICS
1808–1862

A Thesis

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Karen C. Lane

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ABSTRACT

BENEVOLENT SELF-INTEREST:

A FACTOR IN SOCIAL POLICY GOVERNING LUNATICS 1808–1862

by Karen C. Lane

From 1808 to 1862, among the most important social questions confronting England was the plight of the insane poor. Two significant factors, a new, moral approach to treatment and a reform movement led by the bourgeois and upper class, resulted in legislation to rehabilitate the insane and give them a higher quality of life than they suffered in isolation or imprisonment. Pauper lunatics were no longer ejected from the structures of society. Instead, they became members of asylums, protected communities within communities. Likewise, the general public was safeguarded from the erratic behavior of the mentally ill.

Reforms during this period were pivotal in English social history. They form the transition from a medieval system of health care to a centralized system accountable to the government. During these years, bourgeois and upper class benevolent self-interest produced reforms in the poor law institutions that served pauper lunatics.

ACKNOWLEDGEMENTS

Many people deserve recognition for the contributions they have made to my understanding of history and the mentally ill; in fact, they are partners in this thesis. I am pleased to have the chance to acknowledge them publicly.

My mentor at California State University at San Jose, Dr. Irma Eichhorn, taught me to think as a historian. Her academic life was dedicated to pursuing careful scholarship: establishing facts; understanding the geographic, intellectual, cultural, and historical milieux; and interpreting their interrelations. She shared this love of critical scholarship with her students.

Dr. Mary Pickering closely scrutinized several earlier drafts. Her comments and suggestions made this thesis more readable and complete. I cannot adequately express my gratitude to her. Dr. David McNeil, Chair of the Department of History, took time from his busy schedule to read this thesis and point me to valuable sources than would otherwise have been overlooked.

Invaluable assistance was rendered by the staffs of the British Museum and Greater London Record Office in London, England; Broadmoor Hospital, London's former "Bedlam Hospital" that moved to Beckenham, Kent in this century; the National Library of Medicine in Bethesda, Maryland; and the Library of Congress in Washington, D.C. Asylum records from the nineteenth century preserved at the Wellcome Institute in London provided insight into the life and administration of asylums and houses sheltering the insane. Without the aid of these institutions, this thesis would have been impoverished.

Many advocates for the mentally ill and medical researchers imparted their insights into the etiology of severe mental illnesses, their clinical presen-

tations, and treatment modalities. I am especially indebted to the works of E. Fuller Torrey, director of the National Alliance for the Mentally Ill (NAMI) — Treatment Advocacy Center; Daniel Weinberger, Clinical Brain Disorders Branch, National Institute of Mental Health; Sophia Vinogradov, Research Director, Veteran's Hospital, San Francisco; and D. J. Jaffee, NAMI Board Member. Their insights into the plight of the mentally ill planted ideas that developed into this thesis.

A special thank you is owed to Peter Bartlett, Professor of Law, Nottingham University. Dr. Bartlett graciously provided copies of his dissertation, papers, and presentations. His contributions to the study of the mentally ill in eighteenth- and nineteenth-century English poor houses and asylums are unsurpassed.

There is no possible way this thesis could have been completed without the forbearance and support of my husband, Robert, and my children, Kimberly, Richard, and Ryan.

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INTRODUCTION

During the first half of the nineteenth century, the Industrial Revolution created an atmosphere for explosive population growth, migration, and social upheaval. The pauper and poor working classes expanded at a very fast rate. National prosperity resulted in a broader distribution of wealth and an expanding middle class. The rise of the middle class was accompanied by general acceptance of Enlightenment philosophies that placed supreme value on humanity. This rapid growth also resulted in psychosocial stresses that exposed an assortment of mental illnesses. The resultant strain on a decrepit social infrastructure to provide for these people forced social reforms.

This particular study focuses on the treatment and care of insane paupers in England with an emphasis on London and its immediate vicinity. A number of institutions housed the insane: madhouses, workhouses, prisons, hospitals, and asylums. All these could be found near London. As England industrialized, significant segments of the population were displaced. Country people migrated to cities and large towns looking for work. The influx of people put extreme pressures on existing supplies of food, water, shelter, clothing, and sewage systems. Filthy and miserable conditions brought diseases, hopelessness, and despair.

In earlier times, families could quietly or discretely hide lunatic relatives from society or expel them from home and community. When they wandered the countryside, lunatics could be ignored until they committed crimes or became nuisances. Insane paupers could not be easily ignored as they crowded dirty city slums after England shifted from an agrarian to an industrial, urbanized society. Their visible presence and aimless wandering in

urban centers were an embarrassment that could not be ignored by the "Great Nation."

Parliament reacted to the crisis by legislating that local magistrates address the problem. When that failed, Parliament mandated that counties take care of the problem. Uneven implementation of measures to correct the problems led to centralized national action. Bureaucracy burgeoned to meet growing social inequities between the bourgeoisie and the poor. Insane paupers composed the most vulnerable, poorest, and weakest of the social underclasses. How a society treats members of this disadvantaged group defines that society's standard of social justice.

Whenever one entity has arbitrary power over another group, abuses can arise; nevertheless, lunatic paupers in workhouses, almshouses, madhouses, and prisons were not always maltreated. Although there were many "snake pits" abusing lunatics, excellent institutions served them as well. M. A. Crowther writes,

> It would be easy to write a history of the workhouse which concentrated on the scandals, just as it would be easy to write a scandalous history of hospitals, prisons, asylums, public schools, or any institution where one group of people has a fair amount of arbitrary control over another.... The workhouse was the first national experiment in institutional care; many mistakes were made, and both deliberate and unintentional cruelties were perpetrated, but in trying to remedy these, the state was led into creating the specialized institutions which eventually replaced the workhouse.[1]

Scandals and abuses involving pauper lunatics are documented in newspapers, parliamentary documents, and personal records. Focusing only on these

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[1] M. A. Crowther, *The Workhouse System 1834 – 1929: The History of an English Social Institution* (London: Batsford Academic and Educational, 1981), 3.

would be shallow and miss their significance in the evolution of social welfare delivery systems. As abuses were found and documented, officials made corrective adjustments. This social tinkering was an iterative process. The social welfare system was not the result of revolutionary reforms; instead, evolutionary reforms developed into the mental health delivery system that curtailed the abusive exercise of tyrannical power.

This study focuses on the period from 1808 to 1862. Two basic pieces of parliamentary legislation form the boundaries. One boundary is "The County Asylum Act" of 1808. It recommended that magistrates of a single county or group of counties be allowed to authorize the construction of asylums. This recommendation was based on an 1807 report of a Select Committee in the House of Commons. By the end of the eighteenth century, it became apparent that the private sector could not adequately fill the need for supervision and care for the insane. The other boundary is the "Act to Amend the Law Relating to Lunatics" that was passed in 1862. This act consolidated all previous legislation relating to lunatics and allowed voluntary confinement. Many patients chose to remain institutionalized even when they were free to leave. County asylums experienced explosive growth as chronic lunatics were transferred from workhouses.

From 1808 to 1862, among the most important social questions confronting England was the plight of the insane poor. During this time attitudes toward them changed. The stigma of insanity diminished as people began to understand that mental illness could be treated and, in many cases, cured. Two significant factors, a new, moral approach to treatment and a reform movement led by the bourgeoisie and upper class, resulted in legislation to rehabilitate the insane and give them a higher quality of life than they

endured in enforced isolation and imprisonment.[2] Pauper lunatics were no longer ejected from the structures of society: home, family, and community; instead, they became members of asylums, protected communities within communities. They were protected from prying eyes of the curious and blows of the vicious. Likewise, the general public was protected from the erratic behavior of the mentally ill.

The reforms that occurred between 1808 and 1862 were pivotal in English social history. These years form the transition from a medieval system of health care to a centralized system accountable to the government. During these years bourgeois and upper class benevolent self-interest produced reforms in the poor law institutions that served pauper lunatics.

After the pivotal importance of the social service paradigm shift between 1808 and 1862 is acknowledged, one needs to consider why moral treatment alone failed to relieve the suffering of those with mental afflictions. On one hand, the standard of physical care improved; on the other, symptoms of thought, mood, and anxiety disorders persisted. An extended explanation is outside the scope of this thesis. An abbreviated one suffices. For the "walking worried," neurotics with fears and anxiety, humane treatment was and is therapeutically efficacious. For the severely mentally ill with neurobiological

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[2]For a fascinating case history, see Simon Winchester, *The Professor and the Madman: A Tale of Murder, Insanity, and the Making of the Oxford English Dictionary* (New York: Harper Collins, 1998). It recounts the tale of a floridly psychotic American lunatic, a Civil War medical doctor, who murdered a brewery worker in the outskirts of London in 1872. He was found insane and confined to Broadmoor Hospital, an asylum for the criminally insane until the closing years of his life. He was compassionately treated and became a major contributor to the OED. Confinement in Broadmoor protected him and society. The OED would have been impoverished if he had been imprisoned. His treatment and care are a direct consequence of reforms enacted early in the nineteenth century.

disorders, for example psychotics with schizophrenia, manic-depression, and autism, moral treatment proved an ineffective panacea. One cannot cure a neurobiological disorder with kindness and good intentions; nevertheless, it is immoral to treat biological disorders without kindness, compassion, dignity, and humanity. Mental illnesses with a biological etiology must be treated biologically and with moral therapy. The effective treatment of severe mentally illnesses with psychotic features had to wait for the creation of chlorpromazine and reserpine in the 1950's and molecular genetic techniques in the 1980's and 1990's.[3]

Importance of this study

Scholars disagree about the interpretation and significance of the reforms that occurred between 1808 and 1862. Many concoct sinister motives and interpretations. Many of their theories fail the plausibility test. Elaborate conspiracy theories are no more plausible than those devised by supporters of a government cover up of UFOs or the Kennedy assassinations. For these scholars, oppression of the weak and powerless replaces paternalism.

Modern historians have researched the phenomenon of madness in the eighteenth and nineteenth centuries and regard society's response to it as a form of social control. Michel Foucault argued that the bourgeoisie invented the madman because he was a species of pauper that threatened their values.[4]

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[3]For a lucid, accessible account of these developments, see Peter Wyden, *Conquering Schizophrenia: A Father, His Son, and a Medical Breakthrough* (New York: Alfred A. Knopf, 1998) and E. Fuller Torrey, *Surviving Schizophrenia: A Manual for Families, Consumers and Providers* (New York: Harper Perennial, 1995), 18-20.

[4]Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Random House, 1965), 39.

Foucault heavily influenced Thomas Szasz, who singles out the medical community as the chief conspirator in the creation of madness. The medical profession invented mental illness to provide itself with a professional market.[5] Andrew Scull elaborates on the views of Foucault and Szasz by contending that reformers were representatives in a bourgeois conspiracy with the government to remove deviants from society.[6] George Rosen claimed that social stress is related to the rise of mental illness. Society is responsible for causing mental illness. Radical and rapid cultural change induces stress that ultimately causes epidemics; in the eighteenth and nineteenth centuries, social stressors caused epidemics of insanity.[7]

The views of these historians are too cynical and rely on a highly selective filtering of the historical record. In Foucault's case, his Marxist and structuralist presuppositions color his selection and interpretation of the facts: one entrenched group always exercises power to oppress another group to do things they do not want to do. These historians also ignore contravening evidence or engage in semantic games; for example, Scull comments that he has "yet to meet a reformer who conceded that his designs on the objects of his attentions were malevolent."[8] They also ignore the preponderance of evidence that illustrates that mental illness is not a recent formulation. It has ancient roots in Western tradition, civilization, and mythology.

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[5]Thomas S. Szasz, *The Manufacture of Madness* (New York: Harper and Row, 1970), xxv, 160.

[6]Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (New York: St. Martin's, 1979), 14.

[7]George Rosen, *Madness in Society: Chapters in the Historical Sociology of Mental Illness* (Chicago: University of Chicago, 1968), 180.

[8]Scull, *Museums of Madness*, 14.

Ironically Foucault's historiography is antihistorical. It only distinguishes what precedes from what follows like a group of photographs. Jean-Paul Sartre commented incisively:

> At least a dominant tendency, as the phenomenon is not general: the rejection of history. The way Michel Foucault's latest book has become a best-seller is typical ... The success of his book is proof enough that it was something that people were waiting for. Now, truly original thought is never something that people are waiting for. Foucault gives people what they needed: an eclectic synthesis in which Robbe-Grillet, structuralism, linguistics and *Tel Quel* are used one after another to demonstrate the impossibility of historical reflection.[9]

History is not possible when events are treated in isolation from their contextual relationships. Equally damning are Sylvie Le Bon's criticisms. She accuses Foucault of ignoring history and writing unintelligible prose.[10] Furthermore, she accuses him of applying his *a priori* social categories to an alien society.[11]

William of Ockham formulated a principle of scientific investigation, the law of parsimony, in the fourteenth century. The simplest of two or more competing theories is preferable provided that it best explains all of the available data. Ockham's razor, as the principle is also known, has frequently been

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[9]Bernard Pingaud, "Jean-Paul Sartre répond," *L'Arc* 30 (October 1966), 87 in David Macey, *The Lives of Michel Foucault* (London: Hutchinson, 1993), 175.

[10]"Comment supprimer l'histoire? A cet impossible problème, Michel Foucault propose une solution désespérée: n'y pas penser. L'exclure, sinon du réel, au moins du savoir. C'est le propos de son livre, *Les mots et les choses*, et pour le soutenir l'auteur ne recule devant aucun sacrifice. Sacrifier ses prédécesseurs, l'honnêteté et meme son objet d'étude, c'est chose aisée. Foucault va plus loin, il sacrifie son propre ouvrage, préférant l'exposer à la mort par inintelligibilité plutôt que d'abandonner son postulat positiviste." Sylvie Le Bon, "Un positiviste désespéré: Michel Foucault," *Les Temps Modernes* 248 (January 1967), 1299.

[11]Ibid., 1313.

applied too vigorously to oversimplify theories. It can be reasonably argued that Ockham's razor was applied too vigorously in the selection of relevant data upon which theories of madness and civilization were built.

This thesis argues for a simpler and more cogent theory that explains the historical record better than those of Foucault, Rosen, Szasz, and Scull: bourgeois and upper class benevolent self-interest produced reforms in the poor law institutions that served pauper lunatics between 1808 and 1862. The phrase "benevolent self-interest" is oxymoronic. It captures the point of tension and contradiction that the bourgeoisie and upper class often experience. On the one hand, they often want to do good for their fellow man by acting charitably; on the other hand, the bourgeoisie are often characterized by selfishness and the quest for personal advantage. Regarding pauper lunatics, this thesis shows that the tension associated with benevolence and self-interest created a contentious series of reforms in England between 1808 and 1862. Analysis shows that benevolent self-interest results in laws designed to protect lunatics and society. Among the many factors that combine to support this hypothesis are: a belief that insanity was curable, secular and religious humanism, a shift in the treatment paradigm from medical to moral, a desire to seek out and ameliorate social abuses to provide social stability, the unavoidable visibility of lunatics in urban centers, and the paternalism of the aristocracy and bourgeoisie.

This study is important because it clarifies the development of and rationale behind pivotal events in the mental health delivery system. It is also important because it does not seek to impose modern structures, social agendas, and *a priori* hypotheses. It seeks an *a posteriori* explanation for social changes that is informed by modern scientific research.

The roots of England's modern social delivery system originated between 1808 and 1862. This time period marks a transition between private and public mental health delivery systems. Older private madhouses were eventually displaced by newer public asylums. The paradigmatic changes in mental health delivery are characterized by a shift from individuals profiting by lengthy confinement of the insane to public accountability for treatment and care. A disease model of mental illness began to be tempered by an emerging moral model.

The disease model assumes that deviation from the normal state of humanity originates biologically as a result of infectious organisms, physiological malfunctions, or disturbances of normal growth. The disease model requires physical treatment (hence the title "physician"): medicines, purgings, etc. It also presupposes that diseases can be classified by bodily region or system, function, nature of the disease process, cause, and distribution. The disease model insists on an understanding of each malady being treated. It does not necessitate respect for the patient, his suffering, or his psychosocial needs. With the introduction of moral therapy, intangibles outside the disease model were introduced into treatment: occupation, avoidance of physical restraint, and respect for the individual patient.

Humanistic and religious influences resulted in kinder, gentler treatment. Social optimism in treatment to cure insanity was fostered by common knowledge of mentally ill public figures, and their treatment and outcomes. By countering a patient's moral weaknesses, care providers and the public thought that patients could be equipped to overcome their mental illnesses. Being poor and insane was about as low socially as one could fall.

Organization

Lunacy is not a recent invention. Evidence in the Greco-Roman and Judeo-Christian traditions demonstrates that lunacy existed in ancient times. In Western Civilization evidence also exists from the Middle Ages, the Renaissance, Reformation, and post-Reformation Europe. Foucault's formulation and historians who follow in his wake err. Lunacy was not a label used for oppression. It served as a broad diagnostic category for those with dementia, mania, monomania, melancholia, or syphilis. Chapter 1, A Brief History of Lunacy, surveys the evidence and shows lunacy is not a modern phenomenon.

In England, laws governing lunatics developed over many centuries. They appear to be the result of many factors, but legislative reforms were chiefly responses to specific social needs or crises that aligned with the benevolent self-interests of the bourgeoisie and upper class. Legislation between 1808 and 1862 that affected pauper lunatics was the culmination of this process. The evolution of these laws is discussed in Chapter 2, Legislation Affecting Lunatics.

The Industrial Revolution resulted in lunatics congregating in urban centers. Chapter 3, Living Conditions of Lunatics, discusses how the bourgeoisie and upper class moved lunatics into hospitals, madhouses, workhouses, and asylums for the mutual protection of patients and society. Conditions improved when moral treatment supplanted oppressive force and fear, restraints, disregard, isolation, and medical and surgical treatments. The bourgeoisie and upper class advocated kindness, responsibility, and humane treatment that are the hallmarks of moral treatment.

The conclusion synthesizes and summarizes the historical evidence. It concludes that overwhelming evidence supports the thesis that bourgeois and

upper class benevolent self-interest produced reforms in the poor law institutions that served pauper lunatics between 1808 and 1862. This is the most plausible reason for the rise of the public asylum system in nineteenth-century England. The conclusion also makes supplemental observations and suggests additional research topics.

Methodology

This investigation into early nineteenth-century reforms affecting lunatic paupers employs a tripartite methodology. First, sources were critically examined. Second, details relevant to the study were selected. Third, a narrative that will stand the test of critical methods was synthesized from those particular.

Sources

Primary source material comprised government papers, records from institutions that cared for insane paupers, and contemporary histories, biographies, and chronicles. These were obtained from the British Museum, London Records Office, the archives at Bethlehem and Broadmoor Hospitals, the Wellcome Institute, and museums. Primary source material stored at the National Library of Medicine, National Institutes of Health, Bethesda, Maryland supplemented material from England.

Secondary source material is widely available through university libraries and more specialized collections maintained by the British Museum, Wellcome Institute, Library of Congress, and National Library of Medicine.

Selection of Particulars

Source documents were collected, interpreted, and critically evaluated

to determine that they were appropriate, relevant, and adequate to support the thesis. The selection of relevant details is fraught with peril. Prejudice and presuppositions often affect the selection of relevant details. Objectivity and impartiality constitute a high standard to which all historians aspire but seldom achieve; nevertheless, this thesis strives toward this goal. The selection of particulars to support the thesis is not made at the expense of truth or verifiability of the evidence. Once the relevant details were selected, they needed to be fully understood. Accurately penetrating the minds of authors in light of their cultural, historical, religious, and philosophical milieu is required of historians.[12]

Synthesis

The collection of sources and selection of relevant details are preliminary to the main task of a historian: synthesis of the materials. The mere collection of facts is a worthy and needed endeavor, but does not constitute writing history. The handling of source material requires care and technical competence. The potential for error is small in comparison to hypothesis formulation and the establishment of supporting relationships. Synthesis of the sources is a historian's goal. Attention is focused on rational analysis of the sources.

Critical historical analyses and assessments from other historians inform this study. Their insights into the care of insane paupers were critically evaluated based on the available evidence and in light of their philosoph-

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[12]A philosophical basis for understanding and deriving meaning from documents within their setting is expounded by E. D. Hirsch, *Validity in Interpretation* (New Haven: Yale University, 1967); E. D. Hirsch, *The Aims of Interpretation* (Chicago: University of Chicago, 1976).

ical presuppositions. This thesis is a cooperative venture with other historians. The writings of Andrew Scull, George Rosen, Michel Foucault, Anne Digby, M. A. Crowther, and Roy Porter are especially relevant. This thesis builds on their works to expand and evaluate the past just as others will build on this work.

Restrictions and Limitations

A history of pauper lunatics is difficult to reconstruct. Many lacunae exist in the records. Some are easily reconstructed from the existing material. Other information cannot be reconstructed. Lunatic paupers did not leave a record for subsequent generations to study. In addition, many of the records have been intentionally destroyed or have perished through disasters. When institutions closed, primary sources disappeared; nevertheless, material is available from astute observers who wrote in newspapers and testified before parliamentary committees. Eyewitness accounts in books, articles, and personal journals are also available.

This investigation is neither a history of psychiatry nor a history of the evolution of the bureaucracy that arose to administer lunacy, madhouse, and workhouse laws. This is a social history that depends on psychiatric records and material. An understanding of how this bureaucracy evolved is important to comprehend the development of England's national health system. The bureaucracy is discussed where it is relevant to understand the care and treatment of pauper lunatics; however, rapid changes to the bureaucracy caused by almost fifty acts during one century and many Parliamentary investigations mean that a thorough reconstruction, analysis, and appraisal must fall to other researchers.

Definitions

Mental illness is a twentieth-century term but is used by specialists in nineteenth-century Europe. In England, a lunatic was defined to mean every "insane person," and "every person being an idiot," or a person of unsound mind. The terms "idiot," "imbecile," and "feeble minded" were used synonymously to designate people with a diminished intellect.

An asylum was used to describe a house, building, or place providing shelter and care under the provisions of all acts pertaining to lunatics.

A pauper was a destitute, unemployed person with no earthly belongings.

Bethlehem Royal Hospital was the official name for a disreputable institution variously known as "Bethlem Hospital," "Bethlem Asylum," or "Bedlam." Spelling of the name varied.

Use of sexist language

Third person singular pronouns in the English language are masculine, feminine, or neuter. The language has no third person singular common-sex pronoun; nevertheless, English has common-sex general words like *person, anyone, someone, and everyone.* Some writers resort to typographical circumlocution to solve the problem: *s/he, he/she, she/he,* and even *s/he/it.* In American English vernacular *they* does duty for a third person singular common pronoun; i.e., "If someone shouts loudly, *they* will break your eardrums." Another approach to the lack of a common singular pronoun is to alternate the use of masculine and feminine. This is awkward and often times confusing. This thesis will use the scholarly, though somewhat outdated, masculine singular pronoun, *he,* as a common pronoun where either a single male or female

is intended. In the future, the vernacular use of *they* as a common third person singular pronoun will almost certainly become acceptable in scholarly writing.[13]

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[13]Bryan A. Garner, *A Dictionary of Modern American Usage* (New York: Oxford University, 1998), s.v. "sexism."

Chapter 1

ESSENTIAL BACKGROUND FOR UNDERSTANDING THE NINETEENTH-CENTURY PHENOMENA OF MADNESS

The notion of lunacy is found throughout the historical record. Descriptions date to ancient times. Formal categories and definitions vary according to scientific understanding but the phenomena associated with the modern category of severe mental illness remain remarkably stable. Severe mental illnesses are defined by the National Institute of Mental Health to include "disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic-depressive disorder, autism, as well as severe forms of other disorders such as major depression, panic disorder, and obsessive-compulsive disorder."[1] Psychosis, the derangement of personality and loss of rational contact with reality, is common to all the severe mental illnesses. Those afflicted are characterized by bizarre behavior and a loss of social functioning. Although sufficient data is often lacking in the historical record to specify the modern diagnostic category, the presence or absence of psychosis is recognizable.

Mental Illness in Antiquity

Evidence for the existence of mental illnesses before the medieval period is found in ancient Indian, Mesopotamian, Judeo-Christian, and Greco-Roman literature. Evidence in this early period demonstrates that the phe-

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[1][National Advisory Mental Health Council], "Health Care Reform For Americans With Severe Mental Illnesses: Report of the National Advisory Mental Health Council," *American Journal of Psychiatry* 150 (1993): 1447-1465.

nomena associated with severe mental illnesses antedate the industrial period. Ancient literature presents lunacy surrounded by superstition and rationalism. Some cultures believed that demons invaded people. Other civilizations used vague and confusing concepts to explain bizarre behavior. Despite this range of thought, descriptions of lunatics accurately fit modern categories of mental illness. Eventually ignorance and superstition gave way to rationalism, reason, and empiricism. Hippocrates pioneered this paradigm shift; however, almost two millennia were required before it was generally accepted. During the Renaissance and Enlightenment, rationalism finally supplanted superstition. The Judeo-Christian belief in the sovereignty and transcendence of man over creation eventually advanced the paradigm shift by making nature and man objects of study. Man could study phenomena because he was "outside the box."

Ancient India

In the fourteenth century BC, references to psychoses are found in the *Ayurveda*. The *Ayurveda*, the corpus of Indian medicine, is believed to be the most ancient system of medicine in the world. A person plagued by demons was described as "gluttonous, filthy, walks naked, has lost his memory, and moves about in an uneasy manner."[2] During the first century AD, the *Caraka Samhita* mentioned seven types of insanity.[3] Caraka was one of the most cele-

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[2]N. D. C. Lewis, "History of the Nosology and the Evolution of the Concepts of Schizophrenia," in *Psychopathology of Schizophrenia*, ed. Z. P. Hoch and J. Zubin (New York: Grune and Stratton, 1966), 3.

[3]K. C. Dube, "Nosology and Therapy of Mental Illness in Ayurveda," *Comparative Medicine East and West* 6 (1978): 209-228; C. V. Haldipur, "Madness in Ancient India: Concept of Insanity in Charaka Samhita (1st Century A. D.)," *Comprehensive Psychiatry* 25 (1984): 335-344.

brated physicians in India. He accurately described some forms of madness and idiocy (*unmada*), and epilepsy (*apasara*). He enumerated six causes of *unmada*: "(i) improper food, (ii) derangement of the wind, (iii) a combination of wind, bile and phlegm, (iv) strong emotions, (v) violent passions and (vi) poison."[4] Prodromal symptoms of insanity included "feeling of voidness in the head, noises in the ears, anorexia, misplaced mental absorption, anxiety, intoxicated condition of the mind, frequently dreaming of roving." The general symptoms were "confusion of intellect, extreme fickleness of mind, agitation of the eyes, incoherence of speech, mental vacuity, [and] lack of mental ease." The *vatta* type closely mirrors the American Psychiatric Association's *Diagnostic and Statistical Manual Fourth Edition*'s (DSM-IV) category of disorganized schizophrenia, *pitta* describes paranoid schizophrenia, and *kapha* mimics catatonic schizophrenia.[5] The *pishachagraheet* symptoms are: keeping limbs in bizarre position; talking incoherently and irrelevantly on unrelated topics; blocking thoughts; acting ambivalently; having a wandering mind; preferring lonely places; collecting and decorating with rubbish; being dirty, smelly, degraded and dilapidated; and laughing, singing, dancing, and crying without cause.[6] The *Caraka Samhita* observed that such states were difficult to cure when they were hereditary and lasted for over a decade. The descriptions of madness in ancient India resemble late twentieth-century criteria for severe mental illnesses found in DSM-IV.

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[4]J. R. Whitwell, *Historical Notes on Psychiatry: Early Times — End of 16th Century* (London: H. K. Lewis, 1936), 8.

[5]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: American Psychiatric Association, 1994), 286-288.

[6]Dube, "Nosology and Therapy of Mental Illness in Ayurveda," 213.

Ancient Mesopotamia

J. V. Kinnier Wilson documents mental illness in ancient Babylonian literature in the first half of the second millennium BC.[7] He finds descriptions of depression, mania, obsessive-compulsive disorder, epileptic psychoses, delirium, and other psychiatric conditions. He asserts that the evidence for paranoid schizophrenia is unmistakable. A treatment manual prescribes a ritual to be performed.

> If a man has 'mischief makers' who persecute him with tongues, spread rumors, tell tales about him or slander him, if ... evil machinations of man are turned upon him.[8]

A paranoid delusional system caused the victim to think suspiciously that people were crafting a sinister plot against him.

Judaic and Early Christian Attitudes

Early Judeo-Christian literature has had a lasting effect on Western culture and philosophy. The early Judeo-Christian tradition believed that the mentally ill were out of their senses or demon possessed. This condition could be divine retribution for violating God's commands. The threat in Deuteronomy 28:28 is repeated in Zechariah 12:4: "He shall smite thee with madness, and blindness, and astonishment of heart" or, in other words, mania, dementia, and stupor. Descriptions recognizable as forms of severe mental illnesses are found in the Old and New Testaments.

Biblical Hebrew has several words that encompass madness and insan-

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[7]J. V. K. Wilson, "Mental Diseases Of Ancient Mesopotamia," in ed. Don Brothwell and A. T. Sandison, *Diseases in Antiquity: A Survey of the Diseases, Injuries and Surgery of Early Populations* (Springfield, IL: Charles C. Thomas, 1967), 723-733.

[8]Ibid., 727.

ity. שָׁגָע (*shaga*) is a verb with a root meaning, "to be mad." It is used to refer to the demented delirium of a madman who is driven to despair. לְהִלֵּהּ is a verb meaning to amaze or startle. It is used in Proverbs 26:18 to denote passionate, furious madmen engaged in activity that is dangerous to others as well as self: "Like a madman who throws Firebrands, arrows and death...." If madmen are not driven from society, they were restrained and rebuked:

> The Lord has made you priest instead of Jehoiada the priest, to be the overseer in the house of the Lord over every madman who prophesies, to put him in the stocks and in the iron collar, now then, why have you not rebuked Jeremiah of Anathoth who prophesies to you?[9]

Saul, the first king of Israel, apparently suffered from major depression or bipolar disorder.[10] He was terrorized by "an evil spirit" and was soothed by music.

> Now the Spirit of the Lord departed from Saul, and an evil spirit from the Lord terrorized him. Saul's servants then said to him, "Behold now, an evil spirit from God is terrorizing you. Let our lord now command your servants who are before you. Let them seek a man who is a skillful player on the harp; and it shall come about when the evil spirit from God is on you, that he shall play [the harp] with his hand, and you will be well." So Saul said to his servants, "Provide for me now a man who can play well and bring [him] to me." ... So it came about whenever the [evil] spirit from God came to Saul, David would take the harp and play [it] with his hand; and Saul would be refreshed and be well, and the evil spirit would depart from him.[11]

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[9]Jer. 29:26 NASB.

[10]Jeanne M. Slattery, "Who suffers from mental illness?" <http://psy1.clarion.edu/JMS/menillness.html>; Internet; accessed 17 September 2000. Baptist Healthcare System, "Music Therapy," <http://www.baptisteast.com/mus001.htm>; Internet; accessed 17 September 2000. Also, compare Saul's behaviors with diagnostic criteria for two mood disorders, bipolar disorder and depression, in DSM-IV. The details in the biblical account are not complete enough to allow one to distinguish which of two mood disorders Saul suffered from.

[11]1 Sam. 16:14-23 NASB.

The phenomena associated with Saul's depression or bipolar disorder with psychotic features were ascribed to evil spirits. He was gravely depressed and abnormally suspicious. Saul lost contact with reality and his social functioning had deteriorated. David's music provided Saul with relief from his symptoms. In a moment of uncontrollable passion, Saul made a definite but unsuccessful attempt to kill David. The Bible records another of Saul's episodes. He stripped off all his clothes, lay down naked all that day and night, and then tried to kill his own son, Jonathan. After losing all his sons and being in danger of capture by his enemies, he committed suicide.

In the Hebrew scriptures, madmen were shunned. David was captured by King Achish's servants who recognized him. In fear he feigned insanity (טָעַם) and escaped with his life.

> David ... greatly feared Achish king of Gath. So he disguised his sanity before them, and acted insanely in their hands, and scribbled on the doors of the gate, and let his saliva run down into his beard. Then Achish said to his servants, "Behold, you see the man behaving as a madman. Why do you bring him to me? Do I lack madmen, that you have brought this one to act the madman in my presence? [12]

Several observations can be made. Madness was common enough that it could be used as an effective disguise. Achish responded to this feigned madness by expelling David from his presence. When not driven from society, the insane were also silenced by death in ancient Israel: "Come and let us cut her off from [being] a nation! You too, Madmen, will be silenced...."[13]

Three hundred years later, in response to a command from God, Nebuchadnezzar "was driven away from mankind and began eating grass like cat-

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[12]1 Sam. 21:12-22:1 NASB.

[13]Jer. 48:2 NASB.

tle, and his body was drenched with the dew of heaven, until his hair had grown like eagles' [feathers] and his nails like birds' [claws]."[14] This could have been a major depression with psychotic features given his lack of self-care for seven years and subsequent complete recovery.[15] The delusion in which one believes he is turned into an animal in neuropsychiatric disorders is "lycanthropy," werewolfism. People with this condition appear wild and uncontrollable. They avoid social contact and seek solitude away from human abodes.[16]

The New Testament depicts those who are possessed by demons (δαιμονίζομαι) as outcasts of society who lived among the dead. Jesus met two insane men who lived in tombs and were so violent that no one could pass by them. He freed them of their demons who entered a herd of swine that plunged over a cliff to their deaths.[17] Mutism, a symptom of some forms of schizophrenia, was ascribed to demonic possession. When the demon was cast out, the mute was able to speak.[18] The insane were classified with the sick, dead, and lepers.[19] Madmen were not in their right minds.[20]

The attitude toward madmen during the first century continued that of the Old Testament, although Jesus' attitude toward them marked a distinct shift in attitude. Two poles are represented. On one hand, the insane were

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[14]Dan. 4:33 NASB.

[15]Nigel M. Bark, "On the History of Schizophrenia: Evidence of its Existence Before 1800," *New York State Journal of Medicine* 88 (January 1988), 375.

[16]Whitwell, *Historical Notes on Psychiatry*, 24.

[17]Matt. 8:28, Mark 5:12 NASB.

[18]Matt. 9:32 NASB.

[19]Matt. 10:8 NASB.

[20]Mark 5:15 NASB.

societal outcasts who had no place among the living. On the other hand, Jesus' attitude toward the insane was one of acceptance and charity. Nothing was more marked in rabbinic ethics than the stress laid upon charity.[21] This tension between rejection and compassion toward the mentally ill characterized the Christian attitude throughout the Common Era.

Classical Greek Attitudes

The nineteenth-century intelligentsia in England were well educated in classical Greek and Roman authors and history. A liberal education formed a foundation for careers in medicine, education, and politics. The English vocabulary and treatment of madness are derived from Hippocrates, Plato, Aristotle, Galen, and Celsus.

The Greeks had a rich vocabulary for madness. They had several words for different degrees of mental illness. Μανία denotes madness, frenzy, delirium, and, in a weakened sense, it also denotes eccentricity, queerness, excitement. The English word "mania" is derived from this word. Παράνοια is derived from two Greek words, παρά and νοῦς, "beside the mind" or "beside oneself." The word, from which we get the English word "paranoia," denotes madness and foolishness. Παραφρονία and παραφροσύνη are compound Greek words from para and φρονία, meaning "apart from sober-minded." They are translated "madness" or "insanity." Λύττα denotes a mad raving frenzy. Mad desire and insane passion were denoted by οἰστράω. Literally, the verb means to be stung by a gadfly. The metaphorical sense of being stung to madness was

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[21]Claude Joseph Goldsmith Montefiore and Herbert Martin James Loewe, *A Rabbinic Anthology* (New York: Meridian Books, n.d.), 412-414. Also see George Foot Moore, *Judaism in the First Centuries of the Christian Era: The Age of Tannaim*, vol. 2 (Cambridge: Harvard University, 1958), 162-164.

derived from this. Πλάνος is a noun meaning "a wandering" from which the English word "planet" is derived. It is used in conjunction with φρενῶν of a wandering mind or madness. φρενοβλαβής is a noun meaning to be damaged in understanding, deranged. Ἄτη is reckless, impulsive conduct. Used as a proper noun, it referred to the goddess of mischief or reckless conduct. These words represent only a small sampling of the Greek vocabulary that denote madness and insanity.[22] This rich vocabulary illustrates the Greeks' familiarity with the concept of madness and insanity. Their obsession with order, rationality, and the mind motivated them to explore the phenomena associated with insanity. They are credited with making the subject of madness an object of rational inquiry and literary depiction.[23] Three men exemplify the attitudes and treatment of the mentally ill among the Greeks: Hippocrates, the father of medicine; Plato; and Aristotle.

Hippocrates broke from old traditions and introduced the principle of scientific medicine. He attacked belief in the supernatural origin of cerebral and mental diseases. He also denied that magic and faith were related to diseases. Instead diseases arose from bodily, or natural, causes. His article on epilepsy stands as a monument to the principles of scientific medicine in a world dominated by superstition and the supernatural. His treatments were

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[22]These words derive from an electronic search of William Arndt and F. Wilbur Gingrich, *A Greek-English Lexicon of the New Testament and Other Early Christian Literature: A Translation and Adaption of the Fourth Revised and Augmented Edition of Walter Bauer's Griechisch-deutsches Worterbuch zu den Schrift en des Neuen Testaments und der ubrigen urchristlichen Literatur* (Chicago: University of Chicago, 1996) and H. G. Liddell, *A Lexicon: Abridged from Liddell and Scott's Greek-English Lexicon* (Oxford: Oxford University, 1996). The words cited compose a sample of over a hundred words retrieved.

[23]Roy Porter, "Mental Illness," in *The Cambridge Illustrated History of Medicine,* ed. Roy Porter (Cambridge: Cambridge University, 1996), 278.

"based upon clinical observation and the logical processes of induction and deduction. He denied the intervention of deities and demons in the production of disease and its treatment."[24]

Hippocrates attributed distinctions in temperament and personality to different concentrations in the four essential humors: phlegm, yellow bile, black bile, and blood. Excessive phlegm caused dementia. Too much yellow bile occasioned manic rage because it overheated the system. Excess black bile resulted in melancholia. Phlegmatic (sluggish temperament), choleric (easily angered, explosive temperament), and sanguine (cheerfully optimistic temperament) personalities arose from small excesses in blood and the three humors.[25] The free flow of the humors, bodily fluids (e.g., blood, lymph, phlegm, and bile), was essential to a healthy mind. Blockage or imbalance of the humors resulted in cerebral moisture and thus madness or illness. Hippocrates pointedly observed that the brain was the sole source of human emotions and madness.

> Men ought to know that from the brain, and from the brain only, arise our pleasures, joys, laughter and jests, as well as our sorrows, pains, griefs and tears. Through it, in particular, we think, see, hear, and distinguish the ugly from the beautiful, the bad from the good, the pleasant from the unpleasant.... It is the same thing which makes us mad or delirious, inspires us with dread and fear, whether by night or by day, brings sleeplessness, inopportune mistakes, aimless anxieties, absent-mindedness, and

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[24]J. R. Whitwell, *Historical Notes on Psychiatry*, 61.

[25]Hippocrates *Aphorisms* 7; Hippocrates *Humors* 1.1-19, 3.2, 4.14, 7.44, 8.1, 14.12, 20.12. Hippocrates theory is based on four qualities, hot, cold, wet, and dry, which are based on four elements, earth, air, fire, and water. The theory of four elements goes back at least to Empedocles. Plato (*Timaeus* 52d-61c) and Aristotle (*Metaphysics* 1.3.339a) adopted these beliefs. (Cf. Galen's commentary on Hippocrates, *On the Elements According to Hippocrates*; available from <http://ea.pvt.k12.pa.us/medant/Elem.htm>; Internet; accessed 1 October 2000.)

> acts that are contrary to habit. These things that we suffer all come from the brain, when it is not healthy, but becomes abnormally hot, cold, moist, or dry, or suffers any other unnatural affection to which it was not accustomed. Madness comes from its moistness.[26]

Abnormal moisture caused movement of the brain. This caused visual and auditory hallucinations. Patients with too much moisture on the brain spoke in accordance with their hallucinations. After the brain's moisture was normalized, a patient could again think properly. For Hippocrates, insanity was a disease process: it occurred naturally, without supernatural interference in human affairs. Hippocrates can be described as the first biological psychiatrist.

Hippocrates' treatment of insanity included bloodletting, evacuation of the bowels (purgatives), and laxatives (cathartics). These treatments were designed to remove poisons from the system and restore balance to the bodily fluids. He emphasized natural causes, clinical observations, and brain pathology in the study of mental disorders. His treatments persisted until the late nineteenth century.

Plato's anthropology divided the soul into three parts: rational, appetitive (lusts), and spirited-affective. Insanity arose when the rational aspect of the soul no longer controlled human appetites. He believed that a question and answer exchange between philosopher-physician and patient would result in healing insight. Words were to be used to encourage and comfort the patient.[27] Plato's dichotomy between the material and the immaterial per-

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[26]Eric R. Kandel, James H. Schwartz, and Thomas M. Jessell, eds., *Principles of Neural Science*, 3d ed. (Norwalk, CT: Appleton & Lange, 1991), iv.

[27]Plato *Republic* 382e 396a 396b 573c; *Laws* 864d 934c; *Alcibiades* 1:118e 2:138c 2:139d; *Phaedrus* 245a; *Theaetets* 179e; *Lysis* 205a.

vaded his philosophy. His dichotomy between the mind and body caused later Platonists and Neo-Platonists to engage in either licentiousness or asceticism.[28] The Platonists believed that nothing done to the body affected the soul.[29] The Neo-Platonists believed that the body was evil and needed to be subjugated.[30]

Plato also taught what should be done when the head of a household became mentally ill. If a son believed his father was deluded, he first consulted with the elders so a decision could be reached about the father's sanity. If the father was found to be insane, he was kept at home and treated as a minor for the rest of his life.[31]

Plato discussed the tyrannical character that characterized a criminal

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[28]Exploration of Greek dualism's philosophical underpinnings of licentiousness and asceticism is outside the scope of this thesis. Cf. Edwin Hatch, *The Influence of Greek Ideas on Christianity* (New York: Harper, 1957); Philip Schaff, *History of the Christian Church*, vol. 3 (Grand Rapids: Eerdmans, 1979), 147-179; ibid., vol. 2, 442-460; Frederick Copleston, *A History of Philosophy*, vol. 1, *Greece and Rome* (New York: Image Books, 1985), 385-485. Gnosticism, for example, comprised many beliefs that were unified by a commitment to dualism between the material and immaterial worlds. Matter was inherently evil. Only the spirit was redeemable. Nicolaites were licentious and antinomian. Disciples of Basilides and Valentinus were ascetic. Cf. William L. Reese, *Dictionary of Philosophy and Religion* (New York: Humanity Books, 1999), s.v. "Asceticism." Ibid., s.v. "Antinomianism." Ibid., s.v. "Neo-Platonism."

[29]Epictetus gives indications of the later concept of asceticism, i.e., the voluntary adoption of renunciations, privations and self-chastenings, cf. Epictetus *Enchiridion* 47.

[30]Cicero calls the followers of Epicurius *voluptarii* who put obscene lusts in the center (Cicero *Tusculanae Disputationes* III, 40 cf. V, 94). Indeed, Epicurius preferred the lusts of the lower part of the body to the delights of the eyes and the ears (Epicurius *Oratio in Timarchum* 66). Thus, for Epicureans the flesh is regarded as the source of pleasure and especially of uncontrolled sexuality and immoderate gluttony.

[31]Plato *Laws* 929d-e.

psychopath. In an ideal world, judges and doctors would care for those in good physical and psychological health. If madmen were of no use to themselves or society, they should not be treated. He asks, "Will they not leave the sickly in body to die, and put to death those who are incurably warped in mind?"[32] Lunatics and madmen served no purpose. They consumed community resources without making any contributions and were, therefore, deserving of death.

Plato's disciple, Aristotle, adhered to Hippocrates' humoral theory. A balanced life with "all things in moderation" governed Aristotle's ethics and politics. When this principle was violated, problems ensued. Mental imbalance arose when the balance of fluids changed. Aristotle described several emotions including desire, anger, courage, hatred, joy, and fear. [33] When emotions were unchecked and the humors were unbalanced, what was normally good could become detrimental.

> There are persons who cannot have too large a share of these goods: doubtless, for example, the gods. And there are those who can derive no benefit from any share of them: namely, the incurably vicious; to them all the things generally good are harmful. But for others they are beneficial within limits; and this is the case with ordinary mortals.[34]

One of the purposes of the brain was to cool the passions of the heart. Aristotle's separation of the mind from the body was not as rigid as Plato's.

Greek city-states assumed no responsibility for caring for the insane. Only in temples to Aesculapius, the god of healing, did a few of the insane

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[32]Plato *Republic* 571a-567b 406a-410a.

[33]Aristotle *Rhetoric* 1369a-1419b; *Nicomachean Ethics* 1103b-1150a; *Virtues and Vices* 1250a-1251a.

[34]Aristotle *Nicomachean Ethics* 1137a.

receive care that consisted of sleep and dream interpretation. Most of the insane were likely restrained at home, beaten, imprisoned, or driven away.

The Greeks had a fascination with insanity. It was not the product of industrialization, urbanization, stress, or oppression. Madness presented the Greeks, who prized mind and rationality, with a fascinating conundrum discussed by philosophers, treated by physicians, observed by historians, and dramatically presented by playwrights.

Roman Attitudes

Romans were particularly influenced by Greek stoicism, which was the most widely diffused intellectual movement in the Mediterranean world. Stoicism stressed duty and held that through reason man could look upon the physical and moral universe as controlled by fate. Despite appearances to the contrary, the universe was rational and understandable; thus, mankind could imitate the stately calm and order of the universe by accepting circumstances with strict discipline and a tranquil mind (apathy) and achieve a lofty moral worth. Every person, through his reasoning faculty, had the natural resources for living well. Emotional disturbance was an indication of mistaken values: fear, passionate desire, grief, etc., were considered signs of an unhealthy mind, since a virtuous man was in full possession of every good at every moment. The study of Roman stoics like Seneca, Epictetus, and Marcus Aurelius as well as the surviving books of Cicero (not a stoic himself) influenced the development of cosmology and psychology in the western tradition. Stoicism led to a belief that moral deficiencies contributed to the development of madness.

Aulus Cornelius Celsus (10 B.C. - unknown) described three types of

insanity in the second oldest corpus of Greco-Roman medical literature, *De Medicina*. He described phrenitis, a fever-induced delirium; melancholia; and mania. These latter two terms were difficult to differentiate in ancient literature; in fact, Cicero lamented that the Romans failed to differentiate between insanity and frenzy better than the Greeks.[35] Celsus claimed that those afflicted with mania were deceived either by false images or disordered judgments. He condemned over-aggressive medicinal therapy and the use of restraints. The former might be harmful and could not affect the outcome of the disease; the latter might cause injury.[36] His advice would be largely ignored until the late eighteenth century and the nineteenth century.

Galen (A.D. 129-216), the Roman physician, advanced the teachings of Hippocrates that humors existed in normal and abnormal forms and that four qualities were necessary to form human temperaments: hot, cold, dry, and moist. He taught that diseases were caused by external factors like bad air; therefore, a physician needed to determine a disease's symptoms and counteract them.

Galen's influence from the second through the eighteenth century cannot be underestimated. Galen performed experiments and identified key brain and nervous system structures, synthesizing the teachings of Plato, Aristotle, and Hippocrates into a system that went largely unchallenged for 1,700 years. He adopted Plato's bodily system of heart, liver, and brain and connected them to mental states, but he rejected Plato's extreme separation of the mind from the body. Although Galen adopted Aristotle's methods of investigation and

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[35]Cicero *Tusculan Disputations* 3.10-11.

[36]Celus Aurelianus *On Chronic Diseases* 1.144-179.

logic; he rejected the philosopher's belief that the purpose of the brain was to cool the passions of the heart. His synthesis of medicine was based on the Hippocratic Corpus.[37] Melancholy was produced by black bile that was directed toward the brain. When overheated or combined with yellow bile, black bile produced mania.[38] Galen was indeed familiar with insanity. For example, he described a man with fixed delusions who thought that he was made of glass, poisoned and enchanted by his enemies, pursued by demons, and devoid of a head.[39] Galen's death began a decline in the progress of medicine. Following the barbarian invasions in the fifth century, medicine returned to irrationalism and magic.

Summary of the Phenomena of Mental Illness in Antiquity

Many types of mental abnormalities were known in antiquity. Insanity was associated with alcohol, paranoia, delusions, and hallucinations. These psychotic states preceded urbanization and industrialization. The phenomena of mental illness were transcultural. Mental illness is found in ancient Indic, Middle Eastern, and Mediteranean civilizations. Ancient religions held that faith alone was sufficient to cure mental and physical diseases. Nothing suggests that the severely mentally ill were accorded an elevated social status. Nor does the literature suggest that insanity and madness were categories used to oppress or exploit a social or economic class in antiquity. Madness was a phenomenon to be studied and understood. Roy Porter, a medical historian,

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[37]Vivian Nutton, "The Rise of Medicine," in *The Cambridge Illustrated History of Medicine,* ed. Roy Porter (Cambridge: University of Cambridge, 1996), 62; Whitwell, *Historical Notes on Psychiatry,* 84.

[38]Whitwell, *Historical Notes on Psychiatry,* 88.

[39]Porter, "Mental Illness," 281.

writes,

> On the one hand, insanity might be mind at the end of its tether, tortured by the pitiless Fates, at war with itself. Or mental disorder might be somatic, a fever-like delirium, caused by bad blood or bile. The dichotomy between psychological and somatic theories of madness was left for the inheritors of the Greek legacy – and finally for us – to resolve.[40]

The ideas found in the Greek authors were adopted by the Romans. The Roman Empire spread these ideas throughout the Mediteranean, and northern Europe where they survived until the nineteenth-century.

Middle Ages

After the fall of Rome in the fifth century, much of the learning was preserved in Arabic translations as the Western world intellectually declined. The Greek medical tradition passed through Galen and was maintained by Arab Muslims who established asylums in the Middle East as early as the eighth century. Hippocrates' and Galen's writings survived the medieval period in Arabic translations that were retranslated into Latin. Medieval treatments included Hippocrates' and Galen's techniques to balance the humors, exorcisms, and folk remedies. Constantinus Africanus (A.D. 1010 - 1087), a Benedictine monk who was born in Carthage, wrote *De melancholia*. His observations about delusional thinking spread Galen's ideas on melancholy throughout Western Europe. He studied and translated more than thirty works from the Arabic scientific revival including key Greco-Roman texts. These included the classical teachings of Galen and Hippocrates and Islamic medical texts.

Because Islam taught that society is answerable for merciful treatment

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[40]Ibid.

of the mad, Arabs built hospitals with psychiatric wards in Baghdad (750) and Cairo (873). They also built asylums devoted to the insane in Damascus (800) and Aleppo (1270). The first hospitals in Europe devoted to treating the insane were established in Muslim controlled Granada in 1366-1367 and Valencia, Spain in 1407-1409. According to the American Psychological Association Historical Database:

> The founding of the world's first mental hospital was inspired. (*sic*) On [February 24, 1409] in Valencia, Spain, Father Juan Galiberto Jofré came upon a crowd harassing a "madman." Wealthy citizens, led by Lorenzo Salom, responded to a sermon calling for a hospital for the insane. The Hospital de Nuestra Doña Santa Amaria de los Inocentes was founded later in the year and is still in operation.[41]

Beginning in the thirteenth century, hospital wards for madmen could be found in France, Germany, and Switzerland.

During the Middle Ages witchcraft and demon possession were used to account for the behavior of psychotic people. As Patricia Allderidge explains, "The theory of demonical possession as the cause of insanity held sway."[42]

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[41]Available from <http://www.cwu.edu/~warren/calendar/cal10224.html>; Internet; accessed 12 December 1998. This story is reminiscent of the American reformer, Dorthea Dix: "In 1841, a thirty-two year old Sunday School teacher was riveted by the sight of a madwoman bound by chains to the walls of a jail. Thus began Dorthea Dix's lifelong crusade to bring moral treatment to the mentally ill in America, to release them from their societal stigma and remove them to institutional asylums.... Her lobbying efforts in Washington and with Presidents Fillmore and Lincoln were ultimately responsible for the construction of 32 asylums—communities set apart where the mentally ill could be removed from stress and from the punitive eyes of the public." Thomas H. McGlashan, "Psychosocial Treatments of Schizophrenia: The Potential of Relationships," in *Schizophrenia: From Mind To Molecule*, ed. Nancy C. Andreasen (Washington, D.C.: American Psychiatric Press: 1994), 209.

[42]Patricia Allderidge, "Hospitals, Madhouses and Asylums: Cycles in the Care of the Insane," *British Journal of Psychiatry* 134 (1979): 321.

Some of the insane were cared for by religious orders as part of their broader obligation to help the sick. As long as they did not constitute a danger, the insane were allowed to wander medieval Europe.

In 1247, Simon Fitzmary founded the priory of St. Mary of Bethlehem in London for injured crusaders. By 1377, Bethlehem Hospital began accepting the insane. In the middle of the fifteenth century, the Lord Mayor of London, William Gregory wrote about the hospital:

> A chyrche of Owre Lady hat ys namyde Bedlam. And yn that place ben founde many men that ben fallyn owte of hyr wytte. And fulle honestely they ben kepte in that place; and sum ben restoryde unto hyr witte and helthe a-gayne. And sum ben abyding there yn for evyr, for they ben falle soo moche owte of hem selfe that hyt ys uncurerabylle unto man.[43]

Madmen were brought to the hospital to be cured; failing this, they were maintained there. In 1547, the City of London became the custodian for the hospital. The hospital accepted patients from outside London. In 1598, 14% of the patients were from outside London. During the 1630's the hospital was moved and enlarged.

St. Mary of Bethlehem was not the only place in London where lunatics received care. The Book of the Foundation of Saint Bartholomew's Church in London was originally written between 1174 and 1189.[44] The text narrates details of fifty-seven miracles performed in the eleventh century by Saint Bar-

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[43]James Gairdner, ed. *The Historical Collections of a Citizen of London in the Fifteenth Century*, (London: Camden Society, 1876), ix. This volume contains the text of William Gregory's chronicle of London.

[44][St. Bartholomew's Priory, London], *The Book of the Foundation of St. Bartholomew's Church in London, the Church Belonging to the Priory of the Same in West Smithfield. Edited from the Original Manuscript in the British Museum, Cotton Vespasian B IX.* Ed. Norman Moore, (London: Oxford University Press, 1923).

tholomew who worked with the poor and infirm. H. A. Wilmer and R. E. Scammon identified twenty-two cases of neurological or psychiatric origin.[45] Those who were healed included a man who wandered in the woods and hills after becoming mad and seized by a terrible unreason. He rent his clothes, threw stones at people, scattered money, and threatened or frightened the populace. Another man lost his wits and reason. He did not know what to do or not to do. He went aimlessly wherever his madness drove him. A woman "completely lost her mind, tore her clothes with her hands, her tongue was unbridled to blasphemy, and ribaldry." She was eventually bound. Another woman conversed with a person that no one else could see.[46]

Two centuries later, Henry VI of England assumed the throne with a family history of insanity. Epidemiological studies demonstrate that many forms of severe mental illness have genetic loding.[47] Henry's great-grandmother, Jeanne de Bourban, lost her good sense and memory for a few months

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[45]H. A. Wilmer and R. E. Scammon, "Neuropsychiatric Patients Reported Cured at St. Bartholomew's Hospital in the Twelfth Century," *Journal of Nervous and Mental Diseases* 119 (1954): 1-22.

[46]"Liber fundacionis ecclesie Sancti Batholomei Londiniarum pertinentis prioratui in Weste Smythfelde," Cotton MSS, Vespasian B IX. See Norman Moore, *The Book of the Foundation of St. Bartholomew's Church in London* (London: Early English Text Society, 1923).

[47]T. Conrad Gilliam and James A. Knowles, "Genetic Linkage Analysis of the Psychiatric Disorders," in *Comprehensive Textbook of Psychiatry*, 6th ed., ed. Harold I. Kaplan and Benjamin J. Sadock (Baltimore: Williams and Wilkins, 1995), 155-164. A LOD score is define to be "A measure of genetic linkage, defined as the log10 ratio of the probability that the data would have arisen if the loci are linked to the probability that the data could have arisen from unlinked loci. The conventional threshold for declaring linkage is a LOD score of 3.0, that is, a 1000:1 ration (which must be compared with the 10:0 probability that any random pair of loci will be unlinked)." Benjamin Lewin, *Genes*, 6th ed. (Oxford University: Oxford, 1997), 1228.

when she was thirty-five. Henry's maternal grandfather, Charles VI of France, became paranoid and suffered psychosis from 1392 to 1422. Between relapses Charles was listless and careless.

> [Charles VI] was saying that he had no wife and no children, that he was not king but a man called George, and he defaced the royal arms on vessels ... He also asserted that he was made of glass ... poor attention was noted in the short remission of 1397. Later he became quite indifferent to death among family and friends and fell into a listless state. By 1405 he was verminous as well as infected having dug a piece of iron into himself; he had to be forcibly washed and retrained to look after himself.[48]

Henry VI was a healthy, precocious, and ambitious teenager but began to experience dementia in his twenties. He suffered from grandiose delusions and paranoia. He demolished buildings at Eton College so that his chapel would be larger than the others. His plans for the foundation of King's College proved too grandiose to complete.[49] His paranoia was evidenced by his vicious treatment of Eleanor, her husband, and his uncle, the "Good" Duke Humphrey of Gloucester. Henry surrounded himself with armed guards because he believed that his uncle wanted to kill him and seize the throne.[50] He tried those who called him a "lunatic," "not steadfast of wit," and a "fool."[51] These prodromal symptoms preceded an eighteen-month incapacity.

While Henry was thirty-one years old, his mental infirmity prevented him from conducting his royal duties. He became mute and unresponsive for three months. He recovered and relapsed several times. He remained mild-spoken, inane, and ineffectual. During the second battle of St. Albans in 1460,

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[48]Basil Fulford Lowther Clark, *Mental Disorder in Earlier Britain: Exploratory Studies* (Cardiff: University of Wales, 1975), 205.

[49]Ibid., 141-142.

[50]Ibid., 129.

[51]Ibid., 34-35.

Henry was placed under a tree "where he laughed and sang."[52] Others ruled with him as a figurehead until 1461 when Edward IV took the throne. While he was a fugitive in 1464, Henry heard voices in his ears for seventeen days before he was apprehended. From 1465 until 1471, Henry was kept in the Tower of London. In 1471, Henry reassumed the throne for a few months before being executed.

Henry's madness was highly visible. His tragic life shows that lunatics were exploited, even when they were members of the ruling class. He was not extolled because of his lunacy nor was he treated as divinely inspired. Henry's life was made pathetic by mental illness. Insanity neither enhanced nor enriched his life. Claims made by historians, such as Foucault, who romanticize mental illness are unsupported by the life of Henry VI.

By the close of the Middle Ages, the mentally ill were grouped with the handicapped, vagrants, and delinquents. Those deemed to be violent were often chained to walls and maltreated. Others, believed to be inhabited by demons, were incarcerated in madmen's towers or expelled from towns by citizens; however, they were not always objects of abuse. They could also be the recipients of mercy, fools who needed care because of God's grace.

The Renaissance

The Renaissance attitude toward the mentally ill was influenced by fear of witchcraft, works by physicians, and the emergence of syphilis. The spirit of the age is captured by Francis Bacon:

> Neither am I of opinion, in this history of marvels, that superstitious narrations of sorceries, witchcrafts, dreams, divinations,

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[52]Ibid., 200.

> and the like, where there is an assurance and clear evidence of the fact, be altogether excluded. For it is not yet known in what cases and how far effects attributed to superstition do participate of natural causes: and therefore howsoever the practice of such things is to be condemned, yet from the speculation and consideration of them light may be taken, not only for the discerning of the offences, but for the further disclosing of nature.[53]

By the close of the Renaissance, superstitions were rejected in light of human understanding of nature. Only when substantial and convincing evidence became available could the supernatural be attributed to observed phenomena. Natural causes and common sense explanations were preferred over appeals to transcendent beings and supernatural powers. The Renaissance marked a transition from the superstitions of the medieval period to the rationality of the Enlightenment. The theory of demonical possession fell into disrepute as human reason gained ascendancy. Greco-Roman categories were applied to madness as the West rediscovered its philosophical and scientific heritage. Ignorance shrouded the phenomena of madness and lunacy because they remained unexplained by Renaissance scientific knowledge and categories. In this atmosphere, suspending judgment until the causes of lunacy could be discerned was more respectable than ascribing lunacy to divine intervention or the supernatural.

At the end of the fifteenth century, two papal inquisitors, Henry Kramer and James Sprenger, wrote *Malleus Maleficarum* (The Witches' Hammer) in 1486. They sought to prove the existence of witches, to identify them, and to punish them. This book depicted witches mainly as women who showed psychotic, hysterical symptoms, or sexual delusions. It suggested that any

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[53]Francis Bacon, *The Advancement of Learning* (London: Henrie Tomes, 1605); available from <http://www1.uni-bremen.de/~kr538/baconadv.html>; Internet; accessed 30 June 1999.

affliction could be a sign of witchcraft and proscribed tortures that would obtain confessions of guilt. Fear of witchcraft resulted in the execution of thousands of people — mostly women — on charges or suspicion of witchcraft. Because witches were possessed by the devil, Kramer and Sprenger called for the death of the devil's host. Many of the people subjected to torture were probably severely mentally ill and had no idea why they were being maltreated. *Malleus Maleficarum* took treatment of lunatics backwards for the next three hundred years. Irrationality and magic unseen since before the Greek and Roman empires dominated treatment until the Renaissance.

Philippus Aureolus Theophrastus Bombastus von Hohenheim — commonly known as Paracelsus — is best known as the German-Swiss physician and alchemist who established the role of chemistry in medicine. In 1520, he wrote *Diseases Which Lead to a Loss of Reason* in which he argued that mental illnesses are not caused by demons. Mental illnesses were natural diseases. He wrote that mania was characterized by intermittent attacks and recoveries. Melancholia involved a gradual loss of reason accompanied by permanent insanity. Forty-three years later Johann Weyer of Holland wrote *De prestigiis daemonum* (1563) in which he criticized *Malleus maleficarum* and refuted beliefs in witchcraft. These refutations, unfortunately, were insufficient to counter the influence of *Malleus maleficarum* on popular opinion.

At the University of Padua, Girolamo Fracastoro, a colleague of Copernicus, had a private medical practice in Verona. He made an intense study of epidemic diseases. He is best known for *Syphilis sive morbus Gallicus* (1530), *Syphilis or the French Disease*, a work in rhyme giving an account of the disease, which he named. The concept of sexually transmitted diseases was new and caused fear of sexual activity paralleled in the late twentieth century by

fears of acquired immune deficiency syndrome (AIDS). Fear of syphilis was buttressed when it was identified as a major cause of dementia and insanity. Fracastoro's work showed that insanity could be linked to natural rather than supernatural causes.

Not only was lunacy a subject of scientific investigation, it also served as a theatrical subject or part of a play's setting. Portrayal of the insane on the English stage was rare before the seventeenth century; afterward, dramatists worked insanity into their plots with abnormal frequency.[54] Jacobean and Elizabethan playwrights knew insanity and portrayed it in their works. Thomas Dekker (1572-1632), John Webster (1580-1632), John Fletcher (1579-1625), and Benjamin Jonson (1572-1637), were contemporaries of William Shakespeare. Their plays depicted madmen in ways that show their audiences were familiar with Bethlem Hospital, its patients, and its abuses. Dekker, for instance, portrayed, in *The Witch of Edmonton,* an insane girl who was touched by an incarnation of the devil in a dog. She ran off the stage and violently beat out her brain. These playwrights vividly portrayed insanity.

William Shakespeare (1564-1616) knew madness and depicted it in his plays: *King Lear, Hamlet,* and *Twelfth Night.* 'Poor Mad Tom' in *King Lear* is a vivid depiction of a psychotic person with whom Shakespeare's audience could identify. In the play, Edgar, the son of the Earl of Gloucester, described his earlier social and economic status before going mad: "A serving man, proud in heart and mind; that curled my hair, wore gloves in my cap, served the lust of my mistress' heart, and did the act of darkness with her."[55] His status deterio-

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[54]R. R. Reed, *Bedlam on the Jacobean Stage* (Cambridge: Harvard University, 1972), 5, 55.

[55]*King Lear* 3.4.85

rated:

> *Edgar*: I heard myself proclaim'd;
> And by the happy hollow of a tree
> Escaped the hunt. No port is free; no place,
> That guard, and most unusual vigilance,
> Does not attend my taking. Whiles I may 'scape,
> I will preserve myself: and am bethought
> To take the basest and most poorest shape
> That ever penury, in contempt of man,
> Brought near to beast: my face I'll grime with filth;
> Blanket my loins: elf all my hair in knots;
> And with presented nakedness out-face
> The winds and persecutions of the sky.
> The country gives me proof and precedent
> Of Bedlam beggars, who, with roaring voices,
> Strike in their numb'd and mortified bare arms
> Pins, wooden pricks, nails, sprigs of rosemary;
> And with this horrible object, from low farms,
> Poor pelting villages, sheep-cotes, and mills,
> Sometime with lunatic bans, sometime with prayers,
> Enforce their charity. Poor Turlygod! poor Tom!
> That's something yet: Edgar I nothing am.[56]

Shakespeare expected his audiences to recognize 'Poor Mad Tom': a filthy Bedlam beggar with matted, unkempt hair who resembled a wild animal more than a man. With a roaring voice, he punctured his limbs, alien appendages that hung from his torso, so that he would know that they were alive and part of his body. Edgar, as 'Poor Mad Tom,' recounted the treatment Bedlam beggars received as they wandered the countryside moving from village to village. When they approached civilization — villages, small sheds that sheltered livestock, or buildings used to grind grain — the residents showed no mercy but showered them with rocks to drive them away. After the madman fled, residents uttered a prayer of thanksgiving for being delivered from danger.

When Gloucester asked 'Poor Mad Tom' what and who he was, Tom

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[56]*King Lear* 2.3.1-21

answered:

> Poor Tom; that eats the swimming frog, the toad, the tadpole, the wallnewt, and the water; that in the fury of his heart, when the foul fiend rages, eats cow dung for sallets; swallows the pold rat and the ditch dog ... who is whipped from tithing to tithing, and stock-punish'd, and imprisoned ... But mice and rats and such small deer have been Tom's food for seven long year.[57]

When 'Poor Mad Tom' was half sane, he ate what he could catch from the water. When he lost his mind in madness, he was seized by uncontrolled anger. In his mad state, he ate whatever he found: animal excrement or dead rats and dogs. Tom was a reject of a society that did not want anything to do with him. The community had no responsibility or duty toward him. He presented a danger to himself and society; consequently, he was severely beaten with whips, his feet and possibly wrists were confined to holes in a heavy timber frame, and he was imprisoned with criminals. He showed no insight into his condition and did not comprehend why he was punished. His punishment probably proved more mystifying than reforming for Tom. When the recipient lacks insight, punishment degenerates into cruelty. Tom's pitiable condition was chronic and hopeless after "seven long years."

The Renaissance opened with madmen and women subjected to torture as a result of religious superstition and ignorance. It closed with a rediscovery of the Greco-Roman heritage that had been preserved in a few pockets of learning and among the Arabs. Like the Greeks, English dramatists found madmen a fascinating subtheme in their plays. Madmen and lunatics were objects of fear and loathing at the close of the sixteenth century. They were hidden, shackled, beaten, punished, imprisoned, and driven from society. The

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[57]*King Lear* 3.4.129-139.

sixteenth century closed with a need to investigate lunacy scientifically.

Seventeenth Century

Robert Burton's *The Anatomy of Melancholy* (1621) comprehensively presented previous medical and psychological thought on melancholy. Burton, an Oxford cleric, also availed himself of religious and philosophical literature of Western civilization. The *Anatomy of Melancholy* was widely read in England and some forms of melancholy became stylish. With the publication of this book, melancholia reached almost epidemic proportions among the bourgeoisie and upper class. Melancholia was called "the English malady." Burton enumerated and discussed "madness, phrenzy, and melancholy."

> Madness is therefore defined to be a vehement form of dotage, or raving without a fever, far more violent than melancholy, full of anger and clamor, horrible looks, actions, gestures, troubling the patients with far greater vehemency, both of body and mind, without all fear and sorrow, with such impetuous force and boldness that sometimes three or four men cannot hold them.[58]

The characteristics that Burton ascribed to madmen were fierceness, danger, and power. Such madness posed a danger to society and to the madmen themselves. Burton believed that Satan was ultimately responsible for depression, despair, and self-destruction. Mentally ill people suffered a spiritual malady best treated spiritually with prayer and fasting.[59]

Spurred by Renaissance discoveries, optimism, and rationalism, the mind and madness became acceptable subjects to study. The elevation of reason prompted philosophers and physicians to study the mind's nature, functions, and limitations to understand what it means to be human. Lunatics,

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[58]Robert Burton, *Anatomy of Melancholy* (New York: Farrar and Rinehart, 1929), 121.

[59]Porter, "Mental Illness," 282.

unreasonable beings, presented a means to advance an understanding of the nature of rationalism and anthropology by observation and experimentation. Thomas Willis (1621-1675) studied the gyri in many vertebrates, including man. Raymond Vieussens (1641-1716) published his *Neurographia Universalis* (1684), a landmark in neuroanatomy. Psychiatry in the seventeenth century threw off the yoke of supernaturalism and magic by replacing them with reason and science. These studies are an early milestone in the study of the brain's physiology and prepared the way for lunacy to be studied as a disease of the brain.

In 1683, Thomas Willis published *Two Discourses Concerning the Soul of Brutes*. He summarized what was known about severe mental illnesses and differentiated between organic causes due to gross brain disease and psychic causes due to disturbed animal spirits. Willis showed that the animus—one's disposition—resided in the brain. The madman could be controlled only by a mixture of discipline and deprivation designed to put down "the raging of the Spirits and the lifting up of the Soul."[60] In *Cerebri anatome* (1664), Willis provided a vivid description of the human brain accompanied by detailed illustrations of dissections. Willis treated melancholy and mania as if they shared a common cause. Mrs. Bolt of Eaton was one of his patients. She suffered from chronic melancholy with intermittent bouts of madness. Willis had her bound with chains to her bed. He bled her and administered an emetic and an enema. After her symptoms failed to abate and he found her ranting, weeping, and singing, he administered ointments and medicines. Unfortunately, the

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[60]Thomas Willis, *Two Discourses Concerning the Soul of Brutes*, trans. S. Pordage (London: Dring, Harper, and Leigh, 1683), 206.

patient died the next day.[61] Willis's treatment of Mrs. Bolt demonstrates that medical treatment for the insane continued to be influenced by the Greco-Roman tradition of attempting to achieve a balance of bodily fluids.

In 1692, Nicolaus wrote about individuals in a manic state who suffered from paranoid and bizarre delusions. These people "fall into various kinds of delirium, some laugh, some are angry, some are sad, some frightened by trivial things. All of them are rash...." He described their behavior as injurious to themselves and others, "for they will injure or sometimes even kill their friends. They jump out of windows, tear their clothes, spit out their food, act ferociously and scowl."[62] Their imbalanced and irrational behavior was consistent with acute psychosis. The account shows that the behavior of lunatics was a curiosity, concern, and a conversation piece. The behavior was not accorded religious significance.

Ideas about the mind first developed by classic Greek philosophers were refined by René Descartes (1596-1650) and John Locke (1632-1704). Contrary to the Thomists, who believed that a human is a unitary amalgam of soul and matter, Descartes believed that the mind or soul exists independently of matter and mysteriously interact. He thought that the animus resided in the pineal gland, a small body within the brain's ventricles. He reasoned that a feedback loop between the body and mind existed. Sense organs caused matter to move through nerves to the pineal gland in the brain and caused the gland to vibrate. These vibrations initiated emotions and caused

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[61]K. Dewhurst, ed. *Willis's Oxford Casebook (1650-52)* (Oxford: Sanford, 1981), 126-127.

[62]Oskar Diethelm, *Medical Dissertations of Psychiatric Interest Printed Before 1750* (New York: S. Karger, 1971), 93.

the body to act. With his pineal gland theory, Descartes introduced what has been called "one of the most powerful tools of all modern physiological research."[63] This innovation was the hypothetical model.[64]

Cartesian dualism separated the soul from the brain and body. This dualism meant that mental disorders were the result of organic disorders rather than demonic activity. In 1644, Descartes published his physics and metaphysics in *Principia Philosophiae.* He dedicated it to Princess Elizabeth, the daughter of Elizabeth Stuart, titular queen of Bohemia. Elizabeth was well-educated and scholarly. During her exile in the Hague, Descartes developed his moral philosophy in correspondence with her. They exchanged letters from May, 1643 until his death in 1650. Descartes diagnosed Elizabeth with melancholy. In a letter, he explained to her that bad thoughts caused bad dreams and bodily disorders. Madness and its effects were an outgrowth of bad thoughts. She challenged his rationalism and detachment. She questioned whether positive thinking and blind faith in God's goodness were the best way to cure mental suffering. Descartes' *Passions of the Soul* systematically developed ideas on medicine and morality that appear seminally in his correspondence with Elizabeth.[65]

Descartes proposed two criteria to separate humans from beasts in *Discourse on the Method of Rightly Conducting the Reason, and Seeking Truth in*

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[63]A. C. Crombie, "Descartes," *Scientific American* 201 (April 1959): 173.

[64]Louise H. Marshall and Horace W. Magoun, *Discoveries in the Human Brain: Neuroscience Prehistory, Brain Structure, and Function* (Totowa, NJ: Humana, 1998), 41.

[65]Andrea Nye, *The Princess and the Philosopher: Letters of Elisabeth of the Palatine to René Descartes* (Lanham: Rowman and Littlefield, 1999), 40-42., 44-46., 89-91.

the Sciences: first, the ability to use words to declare our thoughts to others; second, the ability to act based on knowledge.[66] The insane failed both these criteria because they lost rational contact with reality and their personalities and minds were deranged. People with the disorganized form of schizophrenia as defined in DSM-IV[67] fail to meet Descartes' criteria for humanness. Their speech and behavior are grossly disorganized. By Descartes' standards, they are more like beasts than humans.

Descartes' criteria proved influential in the following centuries by providing a rationale to treat lunatics like dumb beasts rather than suffering humans. Cartesian philosophy, which was embraced in France but not in England, may help to account for the way that the French segregated the insane in the middle of the seventeenth century while the English were more *laissez-faire* in their treatment of the mentally disordered. A French royal edict in 1656 established an infrastructure to detain involuntarily, house, and care for the insane. In the 1660's, *l' Hôpital Général* housed 3,000 patients. Grouped with the mentally ill were indigents, imbeciles, orphans, prostitutes, homosexuals, aged persons, and the chronically ill. Similar incarceration also

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[66]René Descartes, *Discourse on the Method of Rightly Conducting the Reason, and Seeking Truth in the Sciences.* <gopher://wiretap.area.com/00/Library/Classic/reason.txt>; Internet; accessed 30 June 1999.

[67]DSM-IV serves as the bible of psychiatrists. "The fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), published in 1994, is the latest and most up-to-date classification of mental disorders. DSM-IV is used by mental health professionals of all disciplines and is cited for insurance reimbursement, disability deliberations, and forensic matters." Benjamin J. Sadock and Harold I. Kaplan, "Classification of Mental Disorders" in *Comprehensive Textbook of Psychiatry*, 6th ed., ed. Harold I. Kaplan and Benjamin J. Sadock (Baltimore: Wiliams and Wilkins, 1995), 671. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, xv-xxv.*

occurred in Germany although not elsewhere in Europe. On the continent, only custodial care was offered: treatment was not. In England, most of the insane were kept at home or left to roam. A small minority were maintained in charitable establishments, jails, almshouses, nascent workhouses, and hospitals with wards for incurable lunatics.

While Cartesian philosophy developed on the continent, in England John Locke laid the foundation for empirical psychology in his second book, *Essay Concerning Human Understanding* (1690). According to him, sources of all knowledge were sensory experience and intellectual reflection; these sources were not instances of knowledge in the strict sense, but they provided the mind with the material of knowledge. Locke's source of information was introspection and rarely the observation of behavior. The human mind was a blank tablet; there were no innate ideas. Human ideas were simple, the result of passive receptions of daily experience, or complex, the result of sustained mental exercise.[68] He remarked on memory, discernment, comparison, madness, pleasure and pain, the emotions, and the association of ideas. Locke's ideas prepared a philosophical foundation for nineteenth-century reformers. Roy Porter notes,

> And Locke's doctrine of man's malleability and the formation of character by environment both encouraged expectations of

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[68]Studies in psychophysics and sensory physiology demonstrate that the mind is not blank. Nor is the perceptual world formed simply by direct encounters of a naive brain with the physical properties of a stimulus. For example, a tree falling causes vibrations in the air but not sound. "Sound occurs when pressure waves from the falling tree reach and are perceived by a living being." John H. Martin, "Coding and Processing of Sensory Information," in *Principles of Neural Science,* 3d ed., ed. Eric R. Kandel, James H. Schwartz, and Thomas M. Jessell (Norwalk, CT: Appleton & Lange, 1991), 329-331.

> 'reform' and also pointed to the asylum as the site where, by breaking the chains of adverse circumstances, minds could be reformed.[69]

Locke's philosophy of the mind established a basis for a paradigm shift. The Christian belief that the fallen soul must be redeemed before the mind could be restored would be displaced by the secular belief that 'diseased minds' needed to be cured.

The physician–philosopher reemerged at the end of the seventeenth century to care for the insane. The interplay between science and philosophy that informed Galen and the Greco-Roman physicians had been largely absent during the Middle Ages. The seeds of rationalism planted during the Renaissance were coming to fruition at the end of the seventeenth century. Rationality and irrationality were again a subject of philosophers and an object of treatment by physicians.

Eighteenth Century

The rationalism of the Enlightenment displaced the Greco-Roman theories of humors as the cause of mental illness. On admission to hospitals, patients were asked for permission to perform autopsies if they died, so their brains could be studied. Giovanni Battista Morgagni (1682-1771) showed that brain lesions affected functions like speech. Experiments conducted on dogs showed that brain lesions caused paralysis on the contralateral side. Luigi Galvani (1737-1798) designed experiments to show that an electrical impulse passes through a nerve and causes muscular contractions. The creation of electrical current by living organisms was called "animal electricity." Living

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[69]Roy Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Athlone, 1987), 208.

beings were found to be complex machines. New theories and humanist philosophies were developed that resulted in reforms and new treatments for lunatics in the next century. Benedict de Spinoza (1632-1677) claimed that knowledge would set men free. The eighteenth century continued the search to know more and to free man from fear and ignorance.

Franz Joseph Gall (1758–1828), a German physician, developed the science of phrenology based on a belief that brain functions were organized into distinct regions of the brain. The shape of the skull and personality were determined by the underlying brain matter. Irving Kupfermann succinctly summarizes the theory of phrenology.

> Phrenologists believed that the size of specific bumps on the surface of the head reflected the size and degree of function of the underlying brain tissue. Although the experimental evidence for phrenology was eventually rejected, the idea that specific higher functions are associated with distinct cortical regions received strong support from the studies of the aphasias by Pierre Paul Broca, Karl Wernicke, and other clinical neurologists.[70]

Though phrenology was eventually discredited as a pseudo-science, it was significant in the merging of anatomy, developmental biology, physiology, and the study of behavior.[71] Gall laid the foundation for research into the localization of the brain's functioning. He proposed that language and speech were associated with the frontal lobes of the brain. Gall and phrenology were as important in the eighteenth century as Freud and psychoanalysis were in the

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[70]Irving Kupfermann, "Localization of Higher Cognitive and Affective Functions: The Association Cortices," in *Principles of Neural Science*, 3d ed., ed. Eric R. Kandel, James H. Schwartz, and Thomas M. Jessell (Norwalk, CT: Appleton & Lange, 1991), 823.

[71]Eric R. Kandel, "Brain and Behavior," in *Principles of Neural Science*, 3d ed., ed. Eric R. Kandel, James H. Schwartz, and Thomas M. Jessell (Norwalk, CT: Appleton & Lange, 1991), 6.

twentieth.[72] In the history of science, Gall was the bridge between Thomas Willis, and Paul Broca and Carl Wernicke. He heralded a new era in the study of the brain, one in which "the philosopher-psychologists recognized that the mental and organic realms are more than a geographical site."[73] Gall did not address mental illness *per se*; nevertheless, his belief that the brain shaped personality paved the way for subsequent researchers to conclude that the severe mental illnesses were physiological. Furthermore, his theory of localized brain functionality constituted a significant advance beyond Hippocrates' and Galen's humor theory.

The Greco-Roman explanations of mental illness that dominated treatment for over 1,700 years were challenged independently by a French and a Scottish physician. Boissier de Sauvages and William Cullen published their nosologies, classifications of diseases: *Nosologia methodica* (1765) and *Nosology, or a Systematic Arrangement of diseases* (1800). Physicians could no longer look at a set of symptoms and simply diagnose a disease; they had to determine what was causing these symptoms. Diseases now had to be classified according to their patho-anatomical basis, not their symptoms. Fevers and pains were no longer considered diseases in their own right; some causal factor had to be there to classify them as diseases. Sauvages' system used symptoms as a basis for classification. In 1777, Cullen published the essential parts of his Edinburgh lectures in *First Lines of the Practice of Physic*, which suggested that disease was the result of disturbances in the nervous system. Thus he condemned the use of laxatives and purgatives and prescribed only

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[72]E. H. Ackerknecht, *Medicine at the Paris Hospital* (Baltimore: Johns Hopkins, 1967), 172.

[73]Marshall and Magoun, *Discoveries in the Human Brain*, 55.

tonics: medicines such as quinine, camphor, or wine that would either stimulate or sedate the nervous system. The book became Europe's principal text on the classification and treatment of disease. In addition, Cullen coined the terms, neurosis and neurotic. Furthermore, he advocated the use of physical force and fear to control madmen.

> [It is] necessary to employ a very constant impression of fear ... awe and dread – emotions that should be aroused by all restraints that may occasionally be proper ... even by stripes and blows ... although have the appearance of severity, are much safer than strokes or blows about the head.[74]

Cullen was famous for his teaching methods and lectures in English instead of Latin. These lectures drew medical students to Edinburgh from throughout the English-speaking world and propagated Cullen's treatment modalities. The restraints and beatings advocated by Cullen to control lunatics created outcries when abuses were publicized in the nineteenth century. Nevertheless, the harsh treatment that Cullen advocated — physical restraints, beatings, and constant fear — characterized public asylums. Private asylums could be more lenient.

As the eighteenth century closed, the philosophical movement known as the Enlightenment Reformers, under the influence of Enlightenment thought, abolished harsh treatment and respected the mental patient as a person. This movement included such figures as Vincenzo Chiarugi at Santa Maria Nuova in Florence; Quaker William Tuke at the York Retreat in England; Philippe Pinel who removed the fetters from the inmates in the Paris hospital of Bicêtre in 1797; and Benjamin Rush, the father of American

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[74]William Cullen, *First Lines in the Practice of Physic*, 4th ed (Edinburgh: Elliot, 1784), quoted in Richard Hunter and Ida MacAlpine, eds., *Three Hundred Years of Psychiatry* (London: Oxford University, 1964), 478.

psychiatry, who petitioned for humanitarian reforms at Pennsylvania Hospital in 1798.

Pinel's *A Treatise on Insanity* (1801) classified mental illnesses based on empirical observations. Pinel was indebted intellectually to Hippocrates for the belief that if nature was allowed to take its course then mental illness might be cured, and that brain disease or injuries caused mental illness. He claimed that lunacy was caused by hereditary or environmental factors and described how patients could be treated through education, reasoning, and persuasion. The conditions of Bicêtre when he was appointed head of the facility were abysmal.

> When he entered the hospital he found men in chains, in filth, and lying on straw that was rarely changed. Many were naked and without fresh water, quartered in dark damp holes where no fresh air could enter. They were fed through a tiny hole guarded by a heavy iron grille. The attending physicians make their "diagnoses" and recommended "treatment" through the same hole. The inmates might scream for help but their shouts would not be heard. Raggedly dressed, if at all, their skins infected by the filth, they looked tougher than the most hardened and vicious of criminals.[75]

Pinel found the patients at Bicêtre shackled to chains attached to the floors and ceilings because physicians feared for their safety. The patients were restrained by chains, whips, manacles, shackles, leather girdles, straitjackets, and beds. Uncouth, unsympathetic, and unruly attendants were selected for their physical strength and defiant appearance. Attendants needed to be intimidating: not all of them inflicted cruel, physical punishment, but all were strong and threatening. Because the attendants were overworked, conditions were unbearable. "Generally from thirty to fifty patients were assigned to one

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[75]Bernard Mackler, *Philippe Pinel: Unchainer of the Insane* (New York: Franklin Watts, 1968), 62-63.

attendant, who could do what he wished to protect himself and to maintain order."[76] Pinel was repulsed by inhumane treatment of patients.

Under these subhuman conditions, he initiated what he called the moral treatment of insanity. He used physical restraints only if necessary. He helped patients to control their emotions without brainwashing them. He understood that insanity was organic and believed that it could be cured. A patient's cooperation with treatment could be obtained with kindness and firmness. Bernard Mackler describes Pinel's approach to treatment:

> Moral treatment combined gentleness with firmness. It meant giving each patient as much liberty as he could manage, but it also taught him respect for authority. Firmness was necessary at times, but no harm must come to the patient. Moral treatment meant an unvarying routine, which was necessary to maintain the patient's feeling of security and respect for authority. These would help him to gain control over his emotions. The hospital atmosphere should be the same as in a family where the parents are quite strict. To establish this relationship, the doctor must convince the patient that he wishes to help him and that recovery is a real possibility. This concept of moral treatment might be considered a crude beginning of the therapy relationship as it exists today. However, Pinel never detailed the relationship between therapist and patient, although he understood it well.[77]

Pinel is a capstone in the history of the treatment of the mentally ill and serves as a pivotal personality for nineteenth-century treatment. His observations, analytic methods, and enlightened view of the mentally ill paved the way for radical changes in nineteenth century England.

William Tuke founded the York Retreat in England with the support of fellow Quaker benefactors. When a Quaker widow from his community died under strange circumstances in the York Asylum, the need for a safe place where the insane would be humanely treated became evident to him and his

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[76]Ibid.

[77]Ibid., 76-77.

friends. The York Retreat became the prototype for institutions in mid-nineteenth century England. He advocated strict, firm discipline. Tuke believed that the insane needed to be treated like children with parental authority over them. Straightcoats and isolation were used to calm highly agitated patients. Rewards were used to motivate patients who were given as much liberty as they could handle. The staff created a family atmosphere. Attendants formed friendly, personal relations with patients.

The rise of moral therapy at the end of the eighteenth century was a natural outgrowth of the spirit of the times. Moral treatment required compassionate, understanding treatment of innocent sufferers. Three trends combined at the end of the eighteenth century and ushered in reforms. First, a desire to provide equality and justice. This desire was at the heart of the American and French Revolutions. It also played a role during England's Industrial Revolution. Equality and justice were not just for the sane. The principles also applied to the insane. Second, a man had a responsibility and moral *sine qua non* to help his fellow man. The wealthy were obligated to help the poor. The mentally healthy had an ethical duty to help the mentally ill.[78] Finally, the focus of moral treatment was external because the cause of lunacy was believed to be externally induced; that is, a deleterious environment triggered an underlying predisposition or constitutional weakness. The emergence of moral treatment came into conflict with benign neglect and harsh care lunatics often received.

The eighteenth century closed with basic humanitarian values gaining the ascendancy in treating the insane. First, new optimism and faith were

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[78] Ibid., 83.

inspired by biological and sociological views of mental illness and a new confidence in science to find a cure. From a scientific standpoint, Sauvages and Cullen laid a foundation for the investigation of the *causes* of lunacy rather than *descriptions* of its phenomena. Second, reformers proceeded in good faith to revamp the asylum system. The intent of lay reformers and medical practitioners was well founded and intended. Two treatments vied for mind share in England at the end of the eighteenth century: Cullen's harsh treatment and Tuke's moral treatment.

Nineteenth Century

The nineteenth century is characterized by rapid changes in the care and treatment of the insane. Medical science, philosophy, and political events converged in nineteenth-century England to create a paradigm shift. These three influences are investigated in subsequent chapters to show that benevolent self-interest among the elite and bourgeoisie led to improved care and treatment of madmen.

The beginning of psychiatry as a medical specialty can be traced to Pinel's moral therapy at the close of the eighteenth century and to political, social, and scientific developments at the beginning of the nineteenth century. Pinel trained physicians who became heads of French asylums. Jean Etienne Dominique Esquirol (1782-1840), guided by Pinel's empiricism and mode of therapy, wrote *Mental Maladies: A Treatise on Insanity* (1838). In England, Samuel Tuke and John Conolly wrote treatises that changed treatment. Tuke's *Description of the Retreat* (1813) made his father's York Retreat into one of the most renowned moral treatment asylums. John Conolly's *The Treatment of the Insane without Mechanical Restraints* (1856) standardized and

validated Pinel's non-restraint methods.

About the same time as Pinel and William Tuke were advocating kinder treatment for the insane, King George III experienced hallucinations and delusions that were probably caused by porphyria.[79] This illness resulted in a governmental crisis in England and also provoked compassionate treatment for the mentally ill. In 1800, James Hadfield tried to assassinate King George III in the Drury Lane Theatre; afterward, the court found him not guilty of high treason by reason of insanity. Parliament passed emergency legislation[80] that enabled Hadfield to be held in "some suitable place"; otherwise, there were no legal provisions that allowed him to be detained. Daniel M'Naughten (1813-1865) killed the secretary of Sir Robert Peel in 1843 while suffering from delusions. He was found not guilty by reason of insanity and committed to an asylum for the remainder of his life.[81] This landmark case still influences the defense of the mentally ill.[82]

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[79]"In acute intermittent porphyria, also called porphyria hepatica, affected persons have recurrent attacks of abdominal pain and vomiting, weakness or paralysis of the limbs, and psychic changes resembling hysteria.... This condition is transmitted as a dominant trait; it is possibly the most common form of porphyria, with an overall incidence of approximately one per 100,000 population; people of Scandinavian, Anglo-Saxon, and German ancestry seem more susceptible than others." *Encyclopedia Britannica*, 11th ed., s.v., "Porphyria."

[80]*An Act for the Safe Custody of Insane Persons Charged with Offences*, 1800, 39 & 40 Geo. III c. 94.

[81]For an account, see Donald J. West and Alexander Walk, eds., *Daniel M'Naghton: His Trial and the Aftermath* (London: Gaskell Books, 1977). The spelling of M'Naughten's name has several variations in the literature.

[82][Court TV], "Insanity and Other Defenses," Available from <http://www.courttv.com/legalhelp/lawguide/criminal/102.html>; Internet; accessed 3 December 1998.

Implications of Medical Conditions that Cause Psychosis

Some researchers have argued that the paucity of references to insanity before 1800 means that insanity is a recent phenomenon. Szasz argues that severe mental illnesses are a rhetorical creation. They do not exist.[83] Torrey believes that schizophrenia is a modern phenomenon because evidence for it in preindustrialized Europe is scarce.[84] He has argued that it is a result of overcrowding[85] and viral infections.[86] Advocates for a recent origin of psychotic disorders, like schizophrenia, need to show that the plethora of medical conditions that cause psychosis did not exist prior the modern industrialized, urbanized state. They must also refute the evidence presented earlier in this chapter. Psychosis must have existed even if historical references are scarce.

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[83]Szasz argues that "deviant behavior is only 'disease' through rhetorical creation, then there can be no justification for undesired psychiatric intervention in people's lives. The rhetorical paradigm represents a significant threat to institutional psychiatry, for not only is Szasz arguing that psychiatry is non- scientific, and not only is the language inherent in the rhetorical paradigm foreign and unadaptable to psychiatrists practicing the 'normal science,' but without the medical model for protection, psychiatry becomes little more than a vehicle for social control -- and a primary violator of individual freedom and autonomy -- made acceptable by the medical cloak.

"Szasz's rhetorical paradigm suggests that deviance has always been subjected to some sort of rhetorically justified forms of social control. As with the medical/scientific pretensions of psychiatry today, such control always succeeds through mystification which legitimizes it." Richard E. Vatz and Lee S. Weinberg, "The Rhetorical Paradigm in Psychiatric History: Thomas Szasz and the Myth of Mental Illness"; available from <http://www.enabling.org/ia/szasz/vatz2.html>; Internet; accessed 24 September 2000.

[84]E. Fuller Torrey, *Surviving Schizophrenia*, 18-21. Also, see Torrey's *Schizophrenia and Civilization* (New York: J. Aronson, 1980).

[85]E. Fuller Torrey and Robert H. Yolken, "Is Household Crowding a Risk Factor for Schizophrenia and Bipolar Disorder?," *Schizophrenia Bulletin* 24 (Fall 1998): 321-324.

[86]_____, "Could schizophrenia be a viral zoonosis transmitted from house cats?," *Schizophrenia Bulletin* 21 (Summer 1995): 167-171.

Table 1 lists medical conditions known to cause severe mental disturbances.

TABLE 1. Medical Conditions Causing Psychosis[a]

Huntington's disease	Acute intermittent porphyria	Porphyria variegata	Metachromatic leucodystrophy
Familial basal ganglia calcification	Erythropoetic porphyria	Niemann-Pick's disease	Gaucher's disease, adult type
Fabry disease	Kuf's disease	Congenital adrenal hyperplasia	Homocystinuria
Wilson's disease	Haemochromatosis	Ichthyosis vulgaris	Laurence-Moon-Biedl syndrome
G-6-D deficiency	Phenylketonuria	Oculocutaneous albinism	Kartaneger's syndrome
Familial Ataxia	Hyperasparaginaemia	Brain injury or disease	Embolism
Aqueductal stenosis	Ischemia	Brain trauma	Epilepsy-especially temporal lobe
Encephlitis	Narcolepsy	Obstructive Hydocephalus	Cerebrovascular infarction
Neoplasms	Vitamin B_{12} deficiency	AIDS	Syphilis
Tuberculous meningitis	Pellagra	Hypoglycemia	Hepatic encephalopathy
Hyperthyroidism	Lead poisoning	Lupus erythematosus	Multiple Sclerosis
Uremia	Cotard's syndrome	Herpetic encephalitis	Cysticercosis
Cushing's disease	Kleinfelter's syndrome	Turner's syndrome	18q- deletion
5.q11-q13 triplication	Albinism	Favism	Karagener's syndrome
Progressive supranuclear palsy	Cerebral vascular accident (stroke)	Sarcoidosis	Pernicious anemia
Leptospirosis	Cerebral malaria		

a. Compiled from S. W. Lewis, "The Secondary Schizophrenias," in *Schizophrenia*, ed. Steven R. Hirsch and Daniel R. Weinberger, (Oxford: Blackwell Science, 1995), 333; E. Fuller Torrey, *Surviving Schizophrenia*, 115-116.; Richard Jed Wyatt, Darrell G. Kirch, and Michael F. Egan, "Schizophrenia: Neurochemical, Viral, and Immunological Studies," in *Comprehensive Textbook of Psychiatry*, 6th ed., ed. Harold I. Kaplan and Benjamin J. Sadock, (Baltimore: Williams and Wilkins, 1995), 939.

These medical conditions can cause delusions and hallucinations. To believe that all of the medical conditions listed are of recent origins is simply unreasonable. At least some, if not all the conditions, *must* have existed in the distant past.

The relatively meager references to insanity are easily understood: historical records describe the rich and powerful. The insane were marginalized in society so they were not subjects of general interest. Furthermore, useful categories for describing insanity are of relatively recent origin. Once categories are established, they are used. For example, obsessive-compulsive disorder (OCD) was first described by Jean Étienne Esquirol in 1838 and by the beginning of the twentieth century became a subject of study. As recently as 1985, OCD was considered to be relatively rare, affecting 0.05% of the population. It is now believed to have a six month prevalence of about 1.5% and a lifetime prevalence of 2 to 3 percent.[87] Prevalence did not change within a decade; instead, the ability to study a population more precisely improved. Similarly, the phenomena of the severe mental illnesses did not change historically; the ability to define, study, and diagnosis insanity improved because of industrialization and urbanization. In other words, urbanization and industrialization did not cause severe mental illnesses; they facilitated the application of scientific methodologies to insanity. To insist from the scarcity of references to severe mental illnesses throughout history that such disorders did not exist is to ignore human suffering.

Dilip Jeste and his colleagues postulate six reasons for the rarity of his-

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[87]Michael A. Jenike, "Obsessive-Compulsive Disorder," *Comprehensive Textbook of Psychiatry*, 6th ed., ed., Harold I. Kaplan and Benjamin J. Sadock, (Baltimore: Wiliams and Wilkins, 1995), 1219.

torical references to schizophrenia.[88] First, the syndrome- or disease-based approach to the identification and classification of medical illness is fairly recent, dating to the time of Thomas Willis and Thomas Sydenham in the seventeenth century. Second, a physician's livelihood depended on his ability to heal patients; therefore, he was uninterested in chronic, incurable diseases. Third, many mental illnesses were considered to be in the domain of religion and not medicine. This view was reinforced by psychotic symptoms that frequently had religious themes. Many modern patients suffering psychotic symptoms also attribute religious or supernatural causes to them. Fourth, the signs and symptoms of severe mental illnesses had confusing and conflicting terminology. Mania and melancholy were used by many authors as distinct entities; others used them interchangeably. Authors differed in their use of the terms. Some attributed symptoms to mania, and others attributed them to melancholy. Confusion in precisely classifying types of insanity pervades the literature until the descriptive nosologies of Emil Kraepelin (1856-1926) and Eugen Bleuler (1857-1939). Fifth, the severely mentally ill and their families may not have sought medical assistance. Many psychotic patients are unaware of their condition. The World Health Organization found that ninety-seven percent of schizophrenics and forty-seven of severely depressed patients lacked insight.[89] This leads to a predictable consequence: if a person does not think that he is sick then why would he seek treatment? Families may not

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[88]Dilip V. Jeste, *et al.*, "Did Schizophrenia Exist Before the Eighteenth Century?" *Comprehensive Psychiatry* 26 (1985): 494-496.

[89]World Health Organization, *The International Pilot Study of Schizophrenia*, vol. 1. (Geneva: World Health Organization, 1973) in Irving I. Gottesman, *Schizophrenia Genesis: The Origins of Madness* (New York: W. H. Freeman, 1991), 33-34.

have sought treatment because of fear, shame, or a belief that their relative was merely odd or, possibly, gifted. Finally, the manifestation of severe mental illness may have changed over time. For example, catatonic schizophrenia was once more common than it is at the end of the twentieth century. This list of factors influencing the record of schizophrenia applies equally to other forms of severe mental illness.

Nigel M. Bark postulates that the infrequent references to psychotic symptoms in literature is due to the interests of the writers. Madness and schizophrenia are outside normal human experience; depression is part of the experience of all humans.

> The truly mad who are depicted on the stage, as in Jacobean times, not for their literary role but for diversion or often cruel amusement, or occasionally pathos, can sometimes tell us what their contemporaries knew of madness and schizophrenia.[90]

Madness is unrelated to the great universal emotions experienced by everyone. Spinoza posited three primary emotions from which all other emotions were derived: desire, joy, and sorrow. Hobbes suggested that the simple passions included appetite, desire, love, aversion, hate, joy, and grief. Because the insane and lunatics experienced a breakdown of reason and emotion, it was difficult to write about or relate to madness.

Summary

Philosophy played a role in treating the mentally disordered. This is largely because the relation between mind and matter has perplexed philosophers. The teachings of philosophers influenced the treatment and the perception of madness and lunacy. From Plato and Aristotle through Galen to

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[90]Bark, "On the History of Schizophrenia," 381.

Descartes and Locke, philosophy influenced medicine, science, and laws.

A diachronic historiography of western Europe with a focus on England demonstrates that severe mental illness is not a modern phenomenon. Severe mental illnesses are described in terms of observed bizarre behaviors before and throughout the Common Era in Western literature. The phenomena of mental illness are trans-cultural. Each civilization recognized pathological behavior that it attempted to understand and describe. The phenomena they depicted are consistent with mental disorders that the National Institute of Mental Health categorizes as severe mental illness. Madness is not a recent creation of the medical establishment. The earliest literature shows that madness existed in ancient times and was not venerated. Lunatics were objects of derision and ridicule, persons to be pitied. They were on the fringes of society, restrained in attics or outbuildings, imprisoned, or allowed to wander the countryside. The madman's role in society should not be romanticized.

Foucault, Rosen, Szasz, and Scull fail in their historical analysis. This chapter's historic survey of the phenomena of severe mental illnesses conclusively demonstrates that other processes were operative. Foucault's *a priori* historiography of oppressive labeling is specious. Szasz's assessment that modern psychiatry broadened the concept of disease to encompass mental illness is unsupported by history. Social control theorists like Foucault, Rosen, Szasz, and Scull assert that the mentally disturbed were not considered useful in a capitalist society and that a label was a convenient way to put problematic, unproductive people out of the way. They argue that the medical profession and bourgeoisie exerted social control over poor and lower echelons of society to maintain social order. They fail to recognize that the mentally disordered came from all levels of society. They further do not address the question

of causality: Were the mentally disordered poor as a result of their mental state or because they originated among the poor? Social control theorists assume the latter proposition; nevertheless, the historical evidence supports the former perspective. Late twentieth-century studies also show that the severely mentally ill experience greatly diminished earning power. Most actively psychotic individuals are unable to contribute economically to society. Pathological behavioral aberrations are found throughout history. A plausible alternative explanation is required that is supported by historical evidence: the benevolent self-interest of the bourgeoisie and elite motivated reforms affecting the mentally ill in the mid-nineteenth century.

Foucault asserts that at some time in the past, reason encompassed madness. Madness was believed to be just as valuable and legitimate as reason. It was a legitimate form of opposition to the establishment. This chapter's survey of madness shows that it was not a subset of reason in ancient Indian, the Middle Eastern, or Mediteranean civilizations. Instead, madness was an aberration to be studied and expunged or treated. It was disordered thought or mood that endangered lunatic and community. Madness and reason were never equated nor are they placed on equal footing today. It is doubtful that madmen faired better than sane men. Whoever asserts that madmen were not believed to be sick distorts or ignores the historical record.

Contrary to Foucault and Szasz, labeling madness is not a recent phenomenon. Ancient India, Mesopotamia, Greece, and Rome recognized the wide ranging phenomena associated with mental disorders. They described the phenomena, labeled it, and treated it. Deviant, bizarre behavior existed in ancient times, the medieval period, early modern Europe, Enlightenment, and the modern period.

The treatment of the mentally ill can be represented by a quadrant system. One axis distinguishes between biological treatment and psychosocial treatment. The other axis distinguishes between compassionate treatment and harshly censorious treatment. The manner by which treatment was rendered to the mentally ill swung among these poles. By the nineteenth century there was no doubt that madness was a disease or syndrome of the brain.[91] No particular cure for insanity was efficacious although some recovery was more likely to occur with kind treatment than if a madman was treated harshly or like a wild animal.

Views about madness, lunacy, and insanity and treatment modalities underwent a paradigm shift in the nineteenth century. Older ways of treatment would collapse because they were no longer viable. Harsh treatment and benign neglect were about to be replaced in England by kinder, more humane treatments motivated by the benevolent self-interest of the elite and bourgeoisie. This replacement happened because of the convergence of industrialization, urbanization, and philosophical trends on the continent and England, and the progress of science and technology. Successes at the York Retreat and Bicêtre created an atmosphere of optimism: madness could be treated. Several highly visible events and abuses would also occur that focused public and gov-

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[91]Freud's psychoanalytic methods represent a step backward in the understanding of psychosis. Progress in treating severe mental illnesses was arrested during the heyday of psychoanalysis. The reemergence of biological psychiatry between 1950 and 1970 marks the beginning of the end of psychoanalysis. The demise of Freudian thought is recounted in the last chapters of Nathan G. Hale, *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans, 1917 – 1985* (New York: Oxford University, 1995), and also in E. Fuller Torrey, *Freudian Fraud: The Malignant Effect of Freud's Theory on American Thought and Culture* (New York: Harper Collins, 1992).

ernmental resources on reforming the treatment of the insane.[92]

[92]Readers interested in the history of the treatment of mental illness have a wealth of material from which to choose. Histories of medicine, psychiatry, and science are available at specialty libraries. Some histories are written to support a particular epidemiological theory; for example, E. Fuller Torrey theorizes the existence of a viral etiology of schizophrenia because he does not find evidence of schizophrenia before the Industrial Revolution. Torrey, *Surviving Schizophrenia*, 158-160; E. Fuller Torrey, et al., *Schizophrenia and Manic-Depressive Disorder: The Biological Roots of Mental Illness as Revealed by the Landmark Study of Identical Twins* (New York: Basic Books, 1994), 201-203; E. Fuller Torrey and Robert H. Yolken, "Is Household Crowding a Risk Factor," 321-324.

The reader is referred to six histories for more details: Erwin Heinz Ackernecht, *A Short History of Psychiatry*, 2d ed. (New York: Hafner, 1968); Henri F. Ellenberger, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, 2d ed. (New York: Basic Books, 1970); Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University, 1991); Hunter and Macalpine, *Three Hundred Years of Psychiatry*; Stanley W. Jackson, *Melancholia and Depression: From Hippocratic Times to Modern Times* (New Haven: Yale University, 1986); and E. Fuller Torrey, *Schizophrenia and Civilization* (New York: Jason Aronson, 1980).

Chapter 2

ENGLISH LEGISLATION AFFECTING THE MENTALLY ILL

The problems related to lunatics in society were addressed in English common law. English laws prior to 1800 that affected the mentally ill can broadly be classified into three areas: poor laws, lunacy laws, and laws regulating private madhouses. The evolution of these laws through time demonstrates that society desired protection for all its citizens.

Confinement of dangerous lunatics has a long history in England. Laws allowed local authorities to address problems associated with dangerous lunatics. Following King George III's illness and attempted assassination, insanity became a popular subject of discourse. Philosophical trends, especially utilitarianism and romanticism, heavily influenced the parliamentary agenda. Civil unrest and political crises that were caused by urbanization and industrialization created a receptive atmosphere for reforming the care, treatment, and maintenance of the mentally disordered. The intent of the reformers during the first half of the nineteenth century was to act on their humanitarian values to act benevolently toward the mentally ill while protecting the public. The reformers' intent was to cure the insane rather than to provide merely custodial care.

An analysis of the laws that affected lunatic paupers shows that benevolent self-interest influenced their development. The laws show that the unconventional behavior of lunatics made them the subjects of legislation. Lunacy was not the creation of physicians who were seeking to expand their social standing and power. Instead, the laws protected lunatics and the com-

munity. Lunatics were protected from their relatives and others who might take advantage of them or harm them. It also protected society from the mischief of lunatics.

Prior to the Poor Laws

In 1324, the principle of *parens patriae* was codified. This principle asserted that the king controls and protects the persons and property of lunatics and idiots.[1] The king is cast in a parental role and has responsibility for subjects who are unable to survive unaided. Thomas Gutheil, professor of psychiatry at Harvard Medical School, observes, "Applied to commitment, *parens patriae* offers the rationale of a protective mechanism for citizens in need of protection, a mechanism that is at best parental and at worst parentalistic."[2] According to Peter Bartlett, this principle was applied only when significant property was at stake until the beginning of the eighteenth century.[3]

During the reign of Edward III (1312 – 1377), the *Book of Assizes and Pleas of the Crown* records that it was lawful to beat mad relatives with rods. Quarter Session records for the next two hundred years shows that imprisonment and beating of lunatics was commonplace. Although details are sketchy, it is clear that lunatics could also be imprisoned by kinsmen.[4] Between 1348 and 1482, madmen could be confined if it could be established that it was

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[1]*De Prerogativa Regis*, 1324, 17 Edw. II, stat. I, cap. ix (1324).

[2]Thomas G. Gutheil, "Legal Issues in Psychiatry," in *Comprehensive Textbook of Psychiatry*, 6th ed., ed. Harold I. Kaplan and Benjamin J. Sadock (Baltimore: Williams & Wilkins, 1995), 2756.

[3]Peter Bartlett, "The Poor Law of Lunacy," (Ph.D. diss., U. of London, 1993), 45.

[4]*Liber assisarum et placitoriam corone*, 22 Edward III, Plea 56.

probable that they were going to burn a dwelling.[5] These early cases embody the precedents on which the whole Common Law system was based.

Poor Laws

Henry VIII presided over the beginnings of the English Renaissance and the English Reformation. His succession of divorces and marriages put him at odds with the Catholic Church from which he broke when he married Anne Boleyn in January 1533. Henry dissolved the monasteries and confiscated their revenues. When the assets of the monasteries were usurped by Henry, their social infrastructure responsible for social relief, hospitals and asylums, and alms giving to the poor and vagrants could no longer be maintained.

> After the dissolution of the religious orders by Henry VIII the City of London had to buy back three of its monastic hospitals, St Bartholomew's, St Thomas's and Bethlem. These were 'granted' to the City by the king, (St Bartholomew's and Bethlem being the subject of a joint charter in 1547) and together with the two new foundations of Bridewell ... and Christ's Hospital, became the five Royal Hospitals of the City of London.[6]

After the removal of the monasteries, an immense social problem was created that was addressed by Elizabeth in 1601.[7]

In 1597, almshouses were established under Elizabeth for the aged, disabled, and infant poor.[8] Four years later, in 1601, a more comprehensive poor

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[5]22 Edward IV, 45.

[6]*Bethlem Hospital Historical Museum Catalogue* (Colchester, Essex: J. B. Offset Printers, 1976), 4.

[7]Harley Williams, *A Century of Public Health in Britain 1832 – 1929* (London: Soho Square, 1932), 1-2.

[8]*An Act for Erecting Hospitals, or Abiding and Working Houses for the Poor*, 1597, 39 Eliz. I, c. 5.

law was enacted.[9] Legal provisions put local magistrates in charge of people who had no means to support themselves and raised local taxes towards their relief. The law addressed three classes of the needy. Those who could not work received charity. The insane were managed alongside the lame, impotent, old, and blind. Those who could work but could not find a job were provided with labor. Tramps, vagrants, and those who would not work were punished. The Elizabethan poor laws were administered by parish overseers. Relief was given in the parish where the pauper was settled. In the event that he was apprehended in a different parish, he would be resettled.[10] Rules were established for spouses and children to follow the head of the household.

Several Quarter Sessions records show that friends, relatives, or neighbors of madmen could petition the court for relief. They described the danger posed to the community and judges ordered the madman to be held in custody, usually in a house of detention. Expenses were paid by the local parish unless the madman had financial resources, which would be administered by a court appointed guardian. The Sommerset Quarter Sessions records for 1612 show that the court ordered relatives of a madman to be kept "in his own house if [his relatives] can rule him there, or otherwise that they shall cause him to be sent unto the Bridewell."[11] Taunton Sessions records for 1613 describe the case of Emma Carter from Frome who became insane. Her neighbors feared that she would set fire to homes. The court confined her to the house of correc-

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[9]*An Act for the Relief of the Poor*, 1601, 43 Eliz. I, c. 2.

[10]*An Act for the Better Relief of the Poor of this Kingdom*, 1662, 13/14 Car. II, c. 12.

[11]E. H. Bates, ed., *Quarter Sessions Records for the Country of Somerset* (Somerset: Somerset Record Society, 1907), 1:88.

tion in Ivelchester according to the provisions of the law.[12] In 1648, the Warwickshire court decreed that Daniel Hancox "shalbe *(sic)* forthwith removed from the said Mr. Mulliner and be kept and provided for by the inhitants *(sic)* of the said parish from house to house as heretofore hee hath beene there mainteyned and kept."[13] The courts continued to apply legal principles derived from 1348 and 1482 to madmen in order to protect the community against possible violence.

The Elizabethan Poor Law of 1601 increased the penalties against begging and vagrancy. Madmen and lunatics frequently were treated under the provisions of that law. Michael Dalton's 1618 edition of *The Countrey Justice* grouped lunatics with the elderly, decrepit, infants, orphans, idiots, and physically handicapped. In order to provide for public tranquility, assaults and batteries were made illegal. Exceptions were made for civil authorities and those with 'natural' power over others to "correct and chastise ... any man and his kinsman that is mad."[14]

> It is lawful for the parents, kinsmen or other friends of a man that is mad, or frantic (who being at liberty attempteth to burn a house, or to do some other mischief, or to hurt himself or others) to take him and put him into an *(sic)* house, to bind or chain him, and to beat him with rods, and to do any other forcible act to reclaim him, or to keep him so as he shall do no hurt.[15]

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[12]Ibid., 99.

[13]Warwick County Record Office, *Quarter Sessions Records*, QS 40/3, f44v.

[14]The law restricted the thickness of a rod used to discipline to be no thicker than a thumb. The phrase, "rule of thumb," was derived from this constraint.

[15]Michael Dalton, *The Countrey Justice, conteyning the practise of the Justices of the Peace out of their Sessions* (1618), s.v. "Poore" and "Surety for the Peace."

The practice of confinement and beatings to coerce a madman back to reason had a long history in England. It was an acceptable practice that extended into the nineteenth century. This was partially due to a belief that madness could be driven from a lunatic. It also protected the lunatic from himself and society from the acts of a madman. A lunatic could be chained to prevent mischief while other family members worked or needed to leave their dwelling unsupervised.

Parliament enacted the Bristol Poor Act in 1696. This legislation allowed parishes to form unions, large groups of poor houses that pooled their economic resources, to provide for all of the poor in the city. Previously, each parish bore responsibility to provide for the poor. The new system developed into the workhouse system that eventually spread throughout England. Two years after the parliamentary legislation was enacted, the union of parishes purchased the Bristol Mint building and converted it into the prototype workhouse. The workhouse provided compulsory employment, education, and discipline to the able poor and poor children. In 1707, the first lunatic was admitted, although three years earlier a resident lost his sanity and was sent to Bethlem Hospital in London. The Mint Workhouse was renamed St. Peter's Hospital. Despite the name change, the "hospital" was, in fact, a workhouse according to one of the governors in 1820. A separate ward for lunatics was established by 1767. In 1820, 22.2% of 436 residents were insane. In 1844, the Lunacy Commissioners declared that St. Peter's was unsuitable as a hospital because of the poor conditions.[16]

St. Peter's workhouse/hospital is important because its developmental

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[16]Allderidge, "Hospitals, Madhouses and Asylums," 327.

history was subsequently repeated throughout England. The institution was established to provide for work for the poor so that they would not be a drain on the community. Eventually, workhouses degenerated into containment facilities. They housed the poor and invalids, madmen, and the blind, infirm, and old. Patricia Allderidge remarks, "Wherever workhouses, poorhouses, or houses of industry were set up, these were the most usual places to be used for the accommodation of pauper lunatics."[17]

The Vagrancy Act of 1714 allowed justices of the peace to confine rogues, vagabonds, sturdy beggars, vagrants, and certain lunatics in a secure place. Lunatics, however, were excluded from whippings. Wandering lunatics needed to meet two criteria to be confined: furiously mad and dangerous. The act allowed persons deprived of their reason to be "confined until they recovered their senses." This act forbade vagrants from aimlessly wandering the countryside. Payment came from the vagrant's assets, when they existed, or from parish funds. When a lunatic was not from the local parish, he could be sent back to his last parish of residence.[18]

Knatchbull's Act in 1722 allowed parishes to construct workhouses for able-bodied paupers.[19] In 1744, each county was required to build a house of corrections to quarter ruffians, beggars, vagabonds, and others who "refuse to work for the usual and common wages given to other Labourers in the like Work...." The justice of the peace gave informers a five shilling bounty.

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[17]Ibid., 328.

[18]*An Act for reducing the laws relating to Rogues, Vagabonds, Sturdy Beggars and Vagrants into one Act of Parliament*, 13 Anne cap. 16. This is sometimes referred to as 12 Anne 2 cap. 23.

[19]*Knatchbull's Act*, 1722, 9 Geo. I, c. 7.

Vagrants were then sent to a jail for no more than one month of hard labor. The title of this law clarifies that its intent was to punish laziness, not madness:

> An Act for Reducing the Laws relating to Rogues, Vagabonds, Sturdy Beggars, and Vagrants, into one Act of Parliament; and for the more effectual Punishing such Rogues, Vagabonds, Sturdy Beggars, and Vagrants, and sending them whither they ought to be sent.[20]

Section 20 of The Vagrancy Act of 1744 elaborated on the 1714 Act by requiring violent lunatics to be maintained at the parish's expense until they were cured. Marlene Arieno believes, "'The cure' often took place in private boarding houses, which gradually acquired the name of 'madhouses.'"[21] It is unlikely that the services of a private boarding house were "often" used. The provisions of the law required dangerous lunatics to be "safely locked up in some secure place." This was far more likely to be a jail or house of correction because these places had the infrastructure to prevent escapes. Confinement of lunatics, like that of vagrants, was an act for the common good. Certain features of Section 20 are notable. Local magistrates, who were not required to have medical or legal training, could decide a vagrant's sanity or insanity. No medical certificate was required for confinement or release. This deficiency allowed abuses. False allegations of insanity could result in the restraint of sane vagrants.

In 1782, Gilbert's Act allowed parishes to unite for poor relief. Several

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[20]*An Act to Amend and Make More Effectual the Laws Relating to Rogues, Vagabonds, and Other Idle and Disorderly Persons, and to Houses of Correction*, 1744, 17 Geo. II, c. 5, s. 1.

[21]Marlene A. Arieno, *Victorian Lunatics: A Social Epidemiology of Mental Illness in Mid-Nineteenth-Century England* (Cranbury, NJ: Associated University Presses, 1989), 24.

parishes could combine their resources in the creation and maintenance of one workhouse. This act also allowed able-bodied workers to labor outside the poorhouses. If their earnings were below a threshold, their income was supplemented by the parishes.[22] One unfortunate side effect of this supplement was that wages were artificially driven down for all laborers. Outdoor relief thus tended to perpetuate a class of poor by failing to encourage laborers to improve their lot in life and by driving wages down so that others needed to apply for outdoor relief for salary parity. The wage supplement was reinforced legislatively in 1796.[23]

The poor laws made workhouses institutions of socio-economic tension. They were to deter the able-bodied poor from seeking assistance at the same time as they acted as a refuge for the ailing and helpless. The laws were based on the belief that the deserving and undeserving poor could be distinguished from each other; anyone who accepted relief in the workhouse lacked moral determination to survive outside. The laws were designed to protect society and to punish idleness; unfortunately, lunatics were frequently detained under the poor and vagrancy laws when they were deemed to pose a danger to themselves and others. Regrettably, the laws failed to provide adequate protection for madmen and could be abused by the ignorant and unscrupulous.

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[22]*Gilbert's Act*, 1782, 22 Geo. III, c. 83.

[23]*An Act to Amend so much of an Act, made in the Ninth Year of the Reign of King George I Entitled An Act for Amending the Laws Relating to the Settlement, Employment, and Relief of the Poor, as Prevents the Distributing Occasional Relief to Poor Persons in Their own Houses, Under Certain Circumstances and in Certain Cases*, 1795, 36 Geo. III, c. 23.

The Illness of King George III

George III who was popular in the court and throughout England had an important effect on the general attitude toward madness. This king was plagued by bouts of madness possibly as early as 1762 until his death in 1820. The public respected the courage with which he faced this adversity and admired his piety.

History of His Illness

As early as 1762, when he was twenty-four years old, George III became acutely ill with what was described as a cold. He was "blooded" seven times and "blistered" three times. The purpose of bleeding the king was to release bad humors according to the treatments practiced since Hippocrates and Galen. Blistering caused local swelling under the skin filled with supposedly poisonous humors that could be removed by lancing. In 1765, he developed a mental derangement that was treated with great secrecy. He recovered within a month or two.[24]

In 1788, George III developed a condition that was treated as madness. In retrospect, his symptoms describe a congenital illness, porphyria. George III's symptoms included agitation, forced speech, hoarseness, colic, racing pulse, insomnia, loss of appetite, and fever. One peculiar symptom was purple or blue urine. During acute phases of porphyria, delirium is easily confused with madness. Modern medical textbooks indicate that acute intermittent porphyria is most commonly found in females between twenty and forty years old. Medical symptoms include abdominal crises, burning, prickling, itching, or

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[24]Edward Geoffrey O'Donoghue, *The Story of Bethlehem Hospital from its Foundation in 1247* (New York: E. P. Dutton, 1915), 315-317.

tingling of the skin with no apparent physical cause, and weakness. Psychiatric symptoms include sudden, severe anxiety and mood swings. A patient experiences extremes in excitement and withdrawal, and angry, emotional outbursts.[25]

> Porphyria refers to a group of uncommon inborn or acquired disturbances of porphyrin metabolism. Porphyrins are pigments normally present in hemoglobin, myoglobin, and cytochromes. The classification of porphyrias is based on both clinical and biochemical features....[26]

The most disturbing aspect of George III's illness was his mental confusion from which he recovered after five months. For example, once he delivered a speech for the opening of Parliament, "My Lords and Gentlemen, and Woodcocks cocking up your tails...."[27]

George III experienced two brief episodes in 1801 and 1804. He became chronic in 1810 and was confined to Windsor Castle until his death in 1820. Edward O'Donoghue describes the king's behavior:

> The mania of the king was of an acute character, and was accompanied by definite delusions. He would talk incessantly for hours together, telling anecdotes and sketching the characters of people long dead, analysing *(sic)* his previous illnesses, or repeating passages, relating to madness or blindness, from "King Lear" and "Samson Agonistes." Often, however, he would imagine that he was conversing with the angels, and then he would speak with a smile of infinite pity of those he loved, because they were still tied down to earth and its miseries. Sometimes, however, there were lucid intervals, and in one of them Queen Charlotte entered

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[25]Maurice J. Martin, "Psychiatry and Medicine," in *Comprehensive Textbook of Psychiatry*, 6th ed., ed. Harold I. Kaplan and Benjamin J. Sadock (Baltimore: Williams & Wilkins, 1995), 1640.

[26]George F. Murphy and Martin C. Mihm, Jr., "The Skin," in *Robbins Pathologic Basis of Disease*, 5th ed., ed. Ramzi S. Cotran *et al.* (Philadelphia: W. B. Saunders, 1994), 1205.

[27]John Snow, "The First Advancement: The Treatment of the Insane," *The Asclepiad: A Book of Original Research and Observation in the Science, Art, and Literature of Medicine, Preventive and Curative* 15.4 (1887), 208.

> his apartments, and found her poor blind husband singing a hymn to his own accompaniment on the harpsichord. When he had finished, he knelt down and prayed for his family and people, concluding his fervent supplication by imploring God to deliver him from his heavy calamity, or, at least, to give him strength to bear it. He then burst into tears, and his reason fled.[28]

His Medical Treatment

The treatment of George III's madness in 1788 is well documented and illustrates the best practice of his time. The royal physicians had no experience with madness. They summoned Dr. Thomas Monro of Bethlem Hospital to consult with the Royal physicians when they concluded that the king suffered from madness. Monro's association with Bethlem Hospital made him unacceptable to courtiers; consequently, Reverend Dr. Willis was summoned after he was recommended to the royal physicians by William Pitt and Lady Harcourt. Willis was a clergyman who had for twenty-eight years run a private asylum that housed thirty lunatics in Lincolnshire. He was disliked by the royal physicians because he was not a physician or a member of the same social class. Although he did not have the same education or social standing as they did, he had an excellent reputation of caring for lunatics. Furthermore, their care had failed to relieve the king's symptoms. They brought him in to provide custodial care for the king under their direction; however, Willis had different ideas. He treated the king as his patient and in the same way he treated any of his patients.

Willis wanted complete control of his patient because he feared that family sympathy might interfere with his efforts to cure the king. The Royal family was prevented from seeing the king for weeks. The king's ankles were

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[28]O'Donoghue, *The Story of Bethlehem Hospital from its Foundation in 1247*, 319.

poulticed and painful ulcers developed. Poulticing consisted of "a soft, moist mass of bread, meal, clay, or other adhesive substance, usually heated, spread on cloth, and applied to warm, moisten, or stimulate an aching or inflamed part of the body."[29] An emetic of tartarized antimony was secreted in his meals. When the king failed to cooperate, a straightjacket and bands across his chest and legs bound him to his bed. As his strength improved, violent confrontations ensued.

> George III always maintained that the Willises *(sic)* had behaved towards him with unnecessary severity in 1788 and 1801. Many of the stories told by the king of the violence offered to his royal person were probably exaggerations, but, undoubtedly, he was knocked down, once at least, as "flat as a flounder."[30]

Historian Mary Glover assumes that the king's agitation was a natural response to his rough treatment. "Unfortunately the lesson that harsh treatment makes violent patients, and that violence is often a reaction to fear, was not learned until the nineteenth century."[31] Nevertheless, the king's treatment was in accord with the best practices of the time. This use of fear and force to control insane patients was common practice. Environmental factors — dietary deficiencies, electrolyte imbalances, heavy metals, and poisons — may have contributed to his violence, which was essentially biogenic.[32]

The king's illness was a popular topic of national concern. The unavoid-

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[29]*The American Heritage Dictionary of the English Language*, 3rd ed., s.v. "Poultice."

[30]O'Donoghue, *The Story of Bethlehem Hospital from its Foundation in 1247*, 318.

[31]Mary R. Glover, *The Retreat York: An Early Quaker Experiment in the Treatment of Mental Illness* (York, England: William Sessions, 1984), 100.

[32]Kenneth Tardiff, "Adult Antisocial Behavior and Criminality," in *Comprehensive Textbook of Psychiatry*, 6th ed., ed. by Harold I. Kaplan and Benjamin J. Sadock (Baltimore: Williams and Wilkins, 1995), 1627.

able question asked by the populace was, "If his Royal person could be mistreated like this, how much worse would we be treated?" In clubs and coffeehouses, Tories became despondent and Whigs made merry.[33] The debate had one lasting benefit: insanity and its treatment became an urgent topic of public discourse. Loyal subjects sent scores of popular remedies, "ranging from crab's claw powder to ground ivy, from electricity to ass's blood."[34]

Constitutional Crisis

The king's acute illness in 1788 caused a constitutional crisis. After years of political persecution by James Wilkes, Henry Fox, and Edmund Burke on the floor of Parliament and the loss of the American colonies after the surrender of the British army in 1781, it appeared that the stresses cost the king his sanity. The king's enemies gloated over his condition and calls came for a regent. The Prince of Wales plotted to become regent in the event that the king's condition proved chronic. Six of the seven physicians attending George III refused to predict a speedy recovery for him; Willis was the lone voice that optimistically predicted a speedy recovery. Accusations against Willis were made by the Prince of Wales' allies that Willis had assumed ascendancy over the king. Pitt and the ministers feared the changes that the Prince of Wales might bring to the country should the king's malady be chronic. Five months after the king was afflicted, George III entered St. Paul's Cathedral on April 23, 1789, with his reason restored. The crisis ended with the king's subjects believing that lunacy was curable. This optimism set the cultural climate

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[33]Kathleen Jones, *Lunacy, Law, and Conscience 1744 – 1845: The Social History of the Care of the Insane* (London: Routledge and Kegan Paul, 1955), 42.

[34]Porter, *Mind-Forg'd Manacles*, 170.

for legislative reforms affecting lunatics.

Philosophical Movements

Philosophical ideologies influenced the poor laws and affected lunatics during the nineteenth century: utilitarianism, empirical economics, and romanticism.[35] In the following paragraphs, representatives of these ideologies are mentioned with a synopsis of their major ideas. The implementation of their ideas in legislation between 1808 and 1867 directly affected the care and treatment of lunatics.

Utilitarianism dominated the legislative agenda during the first half of the nineteenth century. Utilitarianism offered a normative ethic based on consequences. It was advanced by Thomas Hobbes (1588 – 1679), William Paley (1743 – 1805), and Jeremy Bentham (1748 – 1832). Bentham taught that there two human masters: pleasure and pain. Pleasure could be used to induce desirable behaviors; pain could discourage undesirable behavior. One utilitarian principle —"The greatest good for the greatest number" — propelled their legislative agenda. Bentham epitomizes the utilitarian stance toward lunatics. Although he thought that lunatics should be under constant supervision and in solitude, he considered medical and moral therapy useless. Inasmuch as he detested legal anomalies, his followers are numbered among the reformers.[36] They sought consistency in treatment and the law without being overly concerned about the nature and quality of care. They also

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[35]For a discussion of differences between orthodox and empirical labor economics, see *Encyclopedia Britannica*, 11th ed., s.v. "Labour Economics," by Ernest Henry Phelps Brown and William Arthur Brown.

[36]Jones, *Lunacy, Law, and Conscience 1744 – 1845*, 67.

searched for expedient solutions.

Thomas Robert Malthus (1766 – 1834) was an empirical economist who was influenced by the skeptic David Hume (1711 – 1776) and Jean-Jacques Rousseau (1712 – 1778). The influence of Thomas Robert Malthus's *An Essay on the Principle of Population as It Affects the Future Improvement of Society, with Remarks on the Speculations of Mr. Godwin, M. Condorcet and other Writers* (1798) cannot be underestimated. He espoused the pessimistic theory that population growth will outrun the food supply and that betterment of mankind's lot is impossible without stern limits on reproduction. Population growth is limited by sustenance and will be constrained by famine, war, and sickness. Imposing strict conditions on the workhouses and outdoor relief recipients was a way to control, limit, and eventually reduce their populace.

Malthus condemned the system of poor law benefits as being a direct incentive to large families and pauperism. He asserted that English poor laws depressed the general condition of the poor in two ways. First, poor law beneficiaries increased the population without a related increase in food production. Second, their consumption of food increased prices for those who labored productively. These side-effects of the poor laws were "strongly calculated to eradicate" the English spirit of independence among the peasantry.[37] Malthus condemned recipients of poor law relief.

> Hard as it may appear in individual instances, dependent poverty ought to be held disgraceful. Such a stimulus seems to be absolutely necessary to promote the happiness of the great mass

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[37]Thomas Malthus, *An Essay on the Principle of Population as it affects the Future Improvement of Society, with Remarks on the Speculations of Mr. Godwin M. Condorcet and other Writers* (London: n.p., 1798); available from <http://wocserv2.socsci.mcmaster.ca/~econ/ugcm/3113/malthus/popu.txt>; Internet; accessed 12 Dec. 1998.

> of mankind, and every general attempt to weaken this stimulus, however benevolent its apparent intention, will always defeat its own purpose. If men are induced to marry from a prospect of parish provision, with little or no chance of maintaining their families in independence, they are not only unjustly tempted to bring unhappiness and dependence upon themselves and children, but they are tempted, without knowing it, to injure all in the same class with themselves. A labourer who marries without being able to support a family may in some respects be considered as an enemy to all his fellow-labourers.[38]

Well-regulated workhouses were needed to replace all forms of outdoor relief for able-bodied workers. Through a policy of repression, the framers of the legislation believed that able-bodied workers would be forced to help themselves and rising wages could be ensured. The legislators wanted the sparse provisions provided by the workhouse to act as a deterrent against able-bodied workers abusing the public's largess. Utilitarian beliefs guided legislation that governed the workhouse. Unfortunately, the legislation rarely made distinctions between the pauper lunatic and the able-bodied sane resident.

William Wordsworth (1770 – 1850), Percy Shelley (1792 – 1822), John Keats (1795 – 1821), and William Blake (1757 – 1827) were numbered among the romantics.[39] The romantics revolted against reason in favor of feelings. They rejected the rationality of Classicism and the Enlightenment in favor of the individual, feelings, the imaginative, and the transcendental. They believed that madness was a sign of creativity. Their works were introspective

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[38]Ibid.

[39]Each of these romantics suffered from severe mood disorders ranging from major depression to bipolar disorder with psychotic features according to research conducted by Kay Redfield Jamison, *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (New York: Free Press, 1993). Jamison is one of the leading authorities on mood disorders and is afflicted with bipolar disorder. An account of her experience with bipolar disorder is found in Kay Redfield Jamison, *An Unquiet Mind* (New York: Knopf, 1995).

with an emphasis on human potential. Romantics expressed themselves in architecture, historiography, literature, music, painting, religion, politics, and philosophy. The misery caused by the Industrial Revolution caused many intellectuals to develop Romantic philosophies of social reform in reaction to utilitarianism and revolutionaries. Evangelical humanism was an expansion of romanticism into Christian anthropology and traces its roots to John and Charles Wesley.

The Criminal Lunatics Act of 1800

Before the Criminal Lunatics Act of 1800, the criminal insane were held accountable for their actions. They were confined in county jails or bridewells. The conditions were horrible. The insane were mingled with all other criminals. The Criminal Lunatics Act of 1800, an *Act for the Safe Custody of Insane Persons charged with Offences*, provided for the detention of criminal lunatics at "his Majesty's pleasure."[40] This act applied to acts of treason, murder and felony. It pertained to individuals who were found to have been insane when the offence occurred or while they were on arraignment. The legislation also affected lunatics who were apprehended under circumstances when it appeared they had intent to commit a crime.

The enactment of the Criminal Lunatics Act of 1800 was precipitated by an attempt on the life of King George III by James Hadfield in 1800. As mentioned in the previous chapter, Hadfield, a former soldier, shot the king and wounded him. His attorney, Thomas Erskine, defended Hadfield using an

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[40]*An Act for the safe Custody of Insane Persons charged with Offences*, 39 & 40 George III c.94.

insanity defense: Hadfield was a lunatic and his attempt on the life of the king was the direct result of a delusional system built around religious themes. Because Hadfield suffered a severe wound to the head with likely brain damage while fighting for the king, he was acquitted despite the enormity and heinous nature of the crime against the crown. Hadfield was committed to Bethlem Hospital because it was one of the few places that accepted the criminally insane.[41]

The Criminal Lunatics Act of 1800 did not provide any provisions about where or how individuals governed by the statute were to be housed; nevertheless, they were usually guarded and shackled in a county jail. Nor did the act specify who would pay the costs of maintaining the criminally insane. These deficiencies in the act would not be legislatively addressed until the 1808 Lunacy Law.

The 1808 Lunacy Law

The 1808 legislation resulted in the construction of eighteen county asylums. In 1806, Sir George Onesiphorus Paul, High Sheriff of Gloucestershire and a Benthamite, decried the condition of pauper lunatics. He was president of the Stroud Society for providing medical attention to the poor. In a letter to the Secretary of State, he wrote:

> I believe there is hardly a parish of any considerable size in which there may not be found some unfortunate human creature of this description who, if his ill-treatment has made him phrenetic, is chained in the cellar or garret of a workhouse, hastened to the leg of a table, tied to a post in an outhouse, or perhaps shut up in an uninhabited ruin; or if his lunacy be inoffensive, left to ramble half naked and half starved through the streets and high-

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[41]*Hadfield's Case* (1800), 27 Howell's St. Tr. 1281.

> ways, teased by the scoff and jest of all that is vulgar, ignorant and unfeeling.[42]

In 1812, Paul privately published a tract favoring public asylums that would unite 'police intention' with 'humanity' and 'economy.'[43]

Although the 1714 Vagrancy Law provided for the commitment of paupers lunatics deemed dangerous, it required two justices to sign the committal order. Then a lunatic could be held as long as the madness continued.[44] The passage of time revealed the law's deficiencies. Several attempts were made to correct the law. In 1744, the provisions of the 1714 law were included in a poor law. "Thus the first statutes authorizing committals of the insane by the state were contained within the poor law."[45] The law did not specify where the insane were to be detained. Most were confined in jail. Some workhouses provided beds and meals for the insane. Bethlem Hospital was not the only charitable facility for the insane. Bethel Hospital, founded in 1713, was England's second oldest public asylum. St. Luke's Hospital opened in London as an alternative to Bethlem Hospital in 1751. Guy's Hospital was founded in 1728 for incurables, including lunatics.

Pauper lunatics detained under the 1744 Lunacy Law were kept mostly in houses of correction and the remainder were in poorhouses or workhouses. "To confine such persons in a common Gaol, is equally destructive of all possibility of the recovery of the insane and the security and comfort of the other

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[42]Published as an appendix to the *1807 Report on Criminal and Pauper Lunatics*.

[43]G. O. Paul, *Observations on the Subject of Lunatic Asylums* (Gloucester: n.p., 1812), n.p.

[44]*An Act for Reducing the Laws Relating to Rogues, Vagabonds, Sturdy Beggars and Vagrants into One Act of Parliament*, 1714, 12 Anne c. 23 (1714).

[45]Bartlett, "The Poor Law of Lunacy," 47.

prisoners."[46] A substantial portion were boarded in private madhouses; nevertheless, the living conditions of lunatics in these establishments were "revolting to humanity."[47] Over half a century later, in 1808, counties were permitted to build asylums[48] thanks to "An Act for the Better Care and Maintenance of Lunatics being Paupers or Criminals in England."[49] This legislation was passed by Parliament in 1808 as the result of a Select Committee that was appointed in 1807. The Select Committee recommendations advanced the care of the mentally disordered from a *laissez faire* age into the asylum age. Private and county asylums eventually played an important role in the care and treatment of the insane.

Prior to the 1808 legislation, asylums were constructed by private subscription. Members of the community promised to underwrite building costs. This legislation provided for asylums that were built on the rates. This made them public facilities for housing the insane until they could be cured. The York Retreat boasted a 50% cure rate.[50] Allderidge commented on the committee's report: "But no one who has read the 1807 Committee's report can doubt the good faith—indeed, the touchingly naïve faith—of the planners. They really believed that asylums were going to cure insanity."[51]

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[46]Ibid.

[47]Ibid.

[48]*An Act for the Better Care and Maintenance of Lunatics, Being Paupers or Criminals in England*, 1808, 48 Geo. III, (1808) c. 96.

[49]*Report of the Select Committee on the State of Criminal and Pauper Lunatics and the Laws Relating Thereto*, 1807, PP 1807 (39) ii 69.

[50]In an age lacking neuroleptics, this rate may seem preposterous; nevertheless, studies of unmedicated patients have about the same recovery rate for low expressed emotion — low conflict environment —patients. McGlashan, "Psychosocial Treatments of Schizophrenia," 193.

[51]Allderidge, "Hospitals, Madhouses and Asylums," 333.

The 1808 Lunacy Law is also known as 'The County Asylum Act' and 'Wynn's Act.' It specified the construction and maintenance of county asylums, admission policies, staff requirements, and finances; the earlier laws did not. Justices of the peace gave notice in Quarter Sessions that they intended to build an asylum. Two or more counties united for construction. The justices increased the county rates to fund asylum construction. The site was to be "an Airy and Healthy Situation, with a good Supply of Water" and was to be located near medical assistance. It was important that patients exercise and engage in outdoor activities. Earlier laws did not regulate where a madhouse was situated or specify how patients were to be regarded and handled. The 1808 legislation dictated that lunatics be kept in clean facilities, physically fit, and with good water, and near medical treatment. This statute was an improvement over earlier Lunacy Laws, which ignored the physical conditions in which madmen were kept. Patients were admitted according to the dangerousness criteria of the 1744 Act.

The statute required that the weekly patient costs incurred by the parishes were not to exceed fourteen shillings. If patients had the financial resources to pay, their total liability was limited to between forty shillings and £10. Visiting justices were to appoint a treasurer and a staff capable of caring for the patients.

The 1808 Lunacy Law was watershed legislation. The rate of reform increased after its passage. The care of the severely mentally ill evolved from a punitive custodial system to one that attempted to cure insanity. Kathleen Jones characterizes the statute:

> The importance of the Act lies primarily in the conception of treatment of a non-deterrent type as a public responsibility, and in the attempt to deal with the root cause—insanity— rather

than with the symptoms of anti-social behaviour.[52]

The importance of the legislation is undiminished by the failure of many counties to construct asylums. The law was amended twice to encourage counties to construct public asylums.[53] The 1815 amendment authorized counties to borrow money for fourteen years to construct asylums. It paved the way for 1834 legislation that allowed the Boards of Guardians authority to build wards for the mentally disordered. 1845 legislation mandated the construction of county asylums that eventually replaced private madhouses.

Laws Regulating Private Madhouses

Private madhouses were regulated starting with legislation in 1774.[54] Parliament intended for the legislation to protect the weak and vulnerable. The 1774 Act for Regulating Madhouses required that if a private home housed at least two lunatics, then a license was required. Houses within seven miles of London needed to be inspected by representatives of the College of Physicians; in the provinces, local justices accompanied by a physician or surgeon who were nominated in Quarter Sessions examined the madhouses. Furthermore, lunatics required certification by a physician, apothecary, or surgeon, and their names had to be registered with the College of Physicians. Thus, only persons licensed by Commissioners responsible to Parliament could operate

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[52]Jones, *Lunacy, Law and Conscience 1744 – 1845*, 75.

[53]*An Act to amend an Act of the Forty eighth Year of His present Majesty, for the better Care and Maintenance of Lunatics, being Paupers or Criminals, in England*, 51 George III c. 79; and *Act to amend an Act passed in the Forty eighth year of the Reign of His present Majesty entitled An Act for the better Care and Maintenance of Lunatics, being Paupers or Criminals, in England*, 55 George III c. 46.

[54]*An Act for Regulating Madhouses*, 1774, 14 Geo. III, c. 49.

madhouses for profit. The law imposed a £500 penalty for failing to send a patient's name to London within three days.

The Lunacy Commissioners met in 1827 to review their findings with the Select Committee. The commissioners had a large quantity of records available from which they could cull valuable information relating to the care and maintenance of the insane. The outcome was the new "Madhouse Act" of 1828. The 1828 Madhouse Act established the Metropolitan Commission in Lunacy to license and inspect asylums.[55] With the establishment of the Commission, the lunatic registry was transferred from the College of Physicians.[56] Fifteen commissioners consisted of five general practitioners with authority to inspect madhouses and asylums only in the metropolitan area. County and public hospitals were still inspected by local justices who reported to the commissioners. The commissioners were required to visit the madhouses and make certain that occupants were lawfully detained and minimum legal standards were adhered to by the operators. Careful record keeping was required: all orders and certificates of admission required to be in order and patients needed to be classified as curable or incurable. Patients were to be treated properly and placed under the supervision of a physician, apothecary, or surgeon.[57] An assessment of each patient's general health formed part of the required medical record. Only a medical attendant or physician could order restraints for unruly

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[55]*An Act to amend the Laws for the Erection and Regulation of County Lunatic Asylums, and more effectually to provide for the Care and Maintenance of Pauper and Criminal Lunatics, in England*, 9 George IV c. 41.

[56]The string of lunacy laws culminated in the Lunacy Act of 1890 that imposed a rigid system of certification that hampered the delivery of services to the severely mentally ill despite the best of intentions. 53 Vict. Ch. 5.

[57]Glover, *The Retreat York*, 2.

patients. Any of the commissioners could order the release of patients whom they believed to be cured. The Lunacy Commission could close a madhouse for non-compliance with the Madhouse Act; thus, the law gave the commissioners the power to deprive offending madhouse operators of revenue.

Many of the commissioners were members of Parliament. Eleven of the first fifteen commissioners were members of Parliament. In the provinces. their duties were fulfilled by local magistrates. The Metropolitan Commission on Lunacy was at the forefront of the reform movement. Several members of the Lunacy Commission were evangelicals who believed that Jesus Christ died on behalf of a fallen world's inhabitants; therefore, all people, including lunatics, possessed intrinsic dignity, value, and worth in the form of the *imago dei* marred by original sin. They applied their religious beliefs to ameliorating social evils associated with the care and maintenance of lunatics.

Anthony Ashley Cooper, Lord Shaftesbury, a social reformer, was the most prominent member of the Metropolitan Lunacy Commission. Between 1828 and 1845, he often served as its chairman. Between 1845 and his death in 1881, he served as the Commission's permanent chairman. Shaftesbury was numbered among the evangelical members of the Lunacy Commission. He placed high value on human life, "There is nothing so economical as humanity."[58] His unrelenting humanitarian efforts included reforms to improve the circumstances of factory and mine workers, the poor, and especially the insane.[59] In 1849, Shaftesbury placed his epileptic son, Maurice,

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[58] Janet Roebuck, *Urban Development in 19th-Century London* (London: Phillimore, 1979), 159.

[59] Arieno, *Victorian Lunatics*, 29.

with a Protestant family in Lausanne, Switzerland.[60] His diary records his parental fears, "I know well the sufferings of an unhappy creature so afflicted when removed from the vigilant eye of personal and parental affection. What will become of him if Minny [Shaftesbury's wife] and I are removed." In 1851, he lamented, "Fits are treated like madness, and madness constitutes a right, as it were, to treat people as vermin."[61]

The 1828 Madhouse Act established a Lunacy Commission empowered to ensure that minimum legal standards were adhered to by the madhouse operators. The commission also spread information relating to the care of lunatics. They helped establish and disseminate the best practices for the care of the insane.

The 1834 Poor Law

The 1834 poor law marked a return to the Elizabethan approach to public aid for the poor. The passage of this poor law was the result of recommendations from a royal commission appointed in 1832. The members of this commission were reacting to the socio-economic turmoil of the times. Migra-

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[60]One might wonder how epilepsy could be associated with madness. "Psychoses are the specific psychiatric disorder most clearly associated with epilepsy." On the Minnesota Multiphasic Inventory, "patients with epilepsy have higher schizophrenia scale and paranoia scale scores than patients with other neurological disabilities." Seizures can influence fluency, comprehension, cognition, and emotions. They can also cause illusions and hallucinations. Mario F. Mendez, "Neuropsychiatric Aspects of Epilepsy," in *Comprehensive Textbook of Psychiatry*, 6th ed., ed. Harold I. Kaplan and Benjamin J. Sadock (Baltimore: Williams & Wilkins, 1995), 199-200.

[61]Anthony Ashley Cooper, Diary, 5 September 1851, The National Register of Archives, London in G. B. A. M. Finlayson, *The Seventh Earl of Shaftesbury* (London: Eyre Methuen, 1981), 335-336; B. Battiscombe, *Shaftesbury* (London: Constable, 1974), 259.

tion from the country into urban centers placed new demands on the delivery of social services. Concurrently, improved manufacturing methods displaced factory laborers.

The agricultural revolution brought immense changes to Great Britain. New agricultural implements and farming methods were introduced. New crops, crop rotation, and mechanization resulted in the need for fewer farm workers to produce food for the country. Displaced farm workers migrated into industrial centers to find work in factories.

The demand for qualified factory labor increased at the same time that impoverished farm workers were migrating into the cities. The demand for qualified labor exceeded the supply. The introduction of industrial machinery helped improve manufacturing methods and efficiency. Cotton textile, steel, iron, and coal industries grew. As the national economy grew and industrialization promoted prosperity, wealth, and new opportunities for many citizens, they can also be said to have caused a considerable amount of hardship and misery for many more. The English prided themselves on their individuality and freedoms. They rejected the notion that the government should regulate the economy. Borrowing from the philosophy of Adam Smith's *Wealth of Nations*, the government was supposed to act like a passive policeman to preserve order and protect private property. The lack of regulation resulted in the rise of the middle class and *nouveaux riches* who had little say about the affairs of state. Wealthy merchants could become peers. The custom of primogeniture forced younger children of the aristocracy into the ranks of the burgeoning middle class. The disparity between the rich and the poor grew wider during this time of social change. In the midst of these tumultuous social changes, a new social conscience emerged. Many became lawyers, doctors, or

bankers. They had influence and money; nevertheless, they did not have the right to vote. Their social conscience and desire for political change created atmosphere for widespread reforms.

Civil Unrest and Political Crisis

The mechanism of Britain's constitutional structure had not changed since 1689 under King William II and Mary II. Despite migration and population growth, the counties and boroughs were represented in the House of Commons by the same number of members as a century and a half before. Britons experienced the full impact of government only at the local level. By 1830, the central government coexisted with an unsystematic hodgepodge of local governments. This resulted in civil unrest and a political crisis. The explosive growth and inequitable political representation of the middle class required parliamentary social reforms to prevent revolution. The bourgeoisie feared that Parliament would maintain the status quo. They would continue to be misrepresented and disenfranchised. The House of Commons needed to be more democratic and directly representative of the population.

Liverpool was succeeded as Prime Minister by Arthur Wellesley, First Duke of Wellington. Wellington was a national hero and reactionary Tory with no sympathy for reform. He served as Prime Minister from 1828 to 1830, when the Tories lost the general election to the Whigs. He fomented a revolutionary atmosphere, strife, and crisis among the powerless bourgeoisie. His entrenched position escalated the reformers' will to enlarge the electorate.

Political leaders arose to meet the constitutional crisis: George Canning and Charles Grey. Between 1822 and 1827, Canning, who was known as Lord Liverpool, served as Prime Minster and began to push for moderate reforms

with a group of younger Tory leaders. These reforms affected criminal codes, trade, labor, and religion. Their passage of the Reform Bill of 1832 helped England avoid revolutionary violence such as swept through France during the Revolution of 1789 and the July Revolution in 1830. Ernst Breisach observed,

> In 1830 the July Revolution in France gave a jolt to the English conviction that gradual development had finally triumphed in France. And it happened at a time when the great reform discussions were intensifying in England. Even the Reform Bill of 1832 did not alleviate the doubts about the idea that revolutionary thrust could be deflected by timely reform.[62]

Charles Grey served as the leader of the Whig Party and Prime Minister from 1830 to 1834. Grey faced constitutional conflicts with the king and Parliament. Agitation by reformers kept the question of reform in the forefront of the Parliament's agenda between 1830 and 1832. He presided over the passage of the Reform Act of 1832 that modernized the franchise and the electoral system.

In 1831, Earl Grey won the approval of the House of Commons for a reform bill on its first reading, but the House of Lords rejected it. In mid-April an opposition amendment passed, and Grey requested that the king dissolve Parliament. The Whigs won a majority on the platform, "The bill, the whole bill, and nothing but the bill." A second reform bill passed the House of Commons and was defeated again in the House of Lords. The ensuing clamor was accompanied by mass meetings and riots. A third bill was passed by the House of Commons to be rejected on amendment in the House of Lords in May 1832. Grey requested that King William IV create new peers so that the bill could

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[62]Ernst Breisach, *Historiography: Ancient, Medieval, and Modern* (Chicago: University of Chicago, 1994), 250.

pass through the House of Lords. The king refused and Grey resigned. Wellington again assumed the prime ministership. Wellington could not form a government, and Grey was reappointed with a royal pledge that peers would be created if needed to pass the reform bill. The pledge was sufficient leverage for the House of Lords to pass the Reform Bill.

This bill redistributed borough seats and created new boroughs. The seats in Parliament were redistributed to promote more evenly distributed representation. It also imposed a uniform borough franchise that increased the total electorate by fifty percent, from 550,000 to 800,000, by extending suffrage to all households who paid at least £10 a year in rent. The Reform Bill of 1832 marked the beginning of a shift from a government representative of the landed aristocracy to one that represented the middle class.

Other reforms quickly followed. William Wilberforce and the Anti-Slavery Society, founded in 1823, saw Parliament abolish slavery in 1833. The Factory Act of 1833 placed restrictions on child labor in the textile industry. Children under nine years old could not be employed in textile mills. Those between nine and thirteen could not work more than nine hours a day and were required to attend two hours of school daily. Children between thirteen and eighteen could not work more than twelve hours a day.

These legal reforms touched many aspects of daily life and came about because of the convergence of social, political, economic, religious, and philosophical trends. If these matters were inadequately addressed, the English social structures could have undergone violent, revolutionary changes. The reformers were utilitarian and pragmatic. Even though they believed in individuality, there was a greater good: social stability. Reformers pragmatically applied the utilitarian principles to their legislative agenda to maximize bene-

fits for the least burden. The reform movement was also the result of a maturing social consciousness: those who have should help the have-nots to achieve a better quality of life and health. To realize their ends, reformers sought to eliminate or equalize injustices. This required that the delivery of government services be standardized and systematized. All areas of government needed to work efficiently for the common good.

The reformers had a broad legislative agenda that touched on slavery, work conditions, education, suffrage, welfare and relief, trade, and crime and punishment. Reforms were not just focused on the insane; nevertheless, governmental policies toward the insane were appropriate targets for their efforts. These policies, however, were inconsistently applied. Consistent policies toward the insane would make all aspects of the government work better. Furthermore, if the government took responsibility for all of its people, then it would be in a better position to serve the most people. Lunacy commissioners administered urban policies affecting the insane, and county magistrates oversaw rural services. The interests of utilitarians, romantics, and empirical economists converged in an uneasy alliance to enact reforms.[63] Walter Arnstein asserts:

> The powers of the central government were on the increase between 1833 and 1854. A central government that had rarely

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[63]An alliance of philosophical and political opponents also occurred during the early 1960s. Liberal and conservative politicians passed legislation that resulted in the closure of psychiatric facilities. Liberals supported legislation because they believed that it liberated oppressed psychiatric patients from the back wards (*à la One Flew Over the Cuckoo's Nest*). Conservatives saw it as an opportunity to save money. This may be the largest failed social experiment in U. S. history. E. Fuller Torrey, *Nowhere To Go: The Tragic Odyssey of the Homeless Mentally Ill* (New York: Harper and Row, 1988), 150-152.

> touched the lives of ordinary individuals and that had shown little concern for their well-being became directly involved with their working conditions, their health, and, to some extent, their education.[64]

Well-to-do families were becoming convinced that the central government should control and reform man-made evils, filth, disease, and human suffering, found in Britain's industrial and urban centers.

Purposes of the New Poor Law

The main purpose of the 1834 Poor Law was to eliminate pauperism. The previous system of poor laws provided outdoor relief, which had the effect of artificially driving wages down. Given two able-bodied laborers, one on outdoor relief and the other not, the able-bodied laborer on outdoor relief could work for lower wages. To cut overhead and increase profits, a merchant or manufacturer would have been foolish to hire labor that was more expensive. In turn, this practice drove the other able-bodied worker onto relief so that he could compete in the labor market. The vicious cycle of poverty that the poor laws reinforced was expressed by a writer for the *London and Westminster Review.*

> I observed in the different countries, that the more public provisions were made for the poor, the less they provided for themselves and of course became poorer.[65]

Not only was the poor law system responsible for creating a vicious cycle of poverty because it interfered with the labor market, it was also expensive.

The escalating costs of poor law administration became uncontrollable.

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[64]Walter L. Arnstein, *Britain Yesterday and Today: 1830 to the Present*, 6th ed. (Lexington: D. C. Heath and Company, 1992), 47.

[65]Ruth G. Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871* (Berkeley: University of California, 1967), 2.

The poor laws forced poor able-bodied laborers into a "Catch-22" situation with two unappealing alternatives. On the one hand, they could work for lower wages and maintain personal dignity by not accepting poor law relief. On the other hand, they could work for lower wages and supplement their income on relief. By accepting relief, they were labeled as vice ridden.[66] Able-bodied recipients of poor law relief were stigmatized. Echoing Malthus, Earl Grey's Poor Law Commission Report questioned their moral condition:

> Every penny bestowed that tends to render the condition of the pauper more eligible than that of the independent labourer is a bounty on indolence and vice.[67]

This was a socially repugnant alternative. Despite this social disincentive, recipients of relief grew to such a degree that between 1802 and 1832 the expenses grew sixty-two percent.[68] Such a dramatic increase in costs in thirty years was unacceptable. A means of separating the deserving able-bodied from the undeserving was required.

Details of the Laws

The expression "The Devil's in the details" is certainly true of the 1834 Poor Law. This legislation was a comprehensive effort to bring many different aspects of previous poor laws into a comprehensive, centrally administered program to relieve indigence. One of the most striking features of the new poor law was consolidation of the workhouses under a centralized authority.

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[66]"Extracts from the information received by His Majesty's Commissioners as to the administration and operation of the Poor Laws...," *Edinburgh Review* 63 (1836), 493-494.

[67]*Report from His Majesty's Commissioners for Inquiring into the Administration and Practical Consequences of the Poor Laws.* PP 1834 (44) xxvii 1.

[68]Anne Digby, *The Poor Law in Nineteenth-Century England and Wales,* (London: Historical Association, 1982), 6.

Fifteen thousand parishes were combined into six hundred unions that were merged into twenty-one districts. The 1834 Poor Law formed a three-tier bureaucracy. At the lowest level were groups of parishes that formed Poor Law Unions. In each of these Unions, a Board of Guardians was elected by the ratepayers with the justice of the peace serving *ex officio* in rural areas. The Board of Guardians managed full-time paid staff: masters and matrons, nurses and medical staff, and teachers. Previously, poor laws were administered by parish volunteers. Overseeing the entire administrative structure was a Poor Law Commission who ensured efficiency and uniformity, which were unheard of in Poor Law history.[69] They hired subordinates and assistant administrators as necessary to oversee the unions. This consolidation was designed to improve the efficiency of administration and control.

The law covered aged and infirm men, able-bodied men and boys over 13, boys from 7 to 13, aged and infirm women, able-bodied women and girls over 13, girls from 7 to 13, and children under 7. The groups of people governed by the law suggest that workhouses infirmaries required staff to help the elderly, sick, and feeble. Moreover, the omission of lunatics and madmen is glaring. Section 45 of the Poor Law contains the only mention of lunatics.

> ... nothing in this Act... shall authorise the detention in any workhouse of any dangerous Lunatic, insane Person, or Idiot for any longer period than 14 days: and every Person wilfully detaining in any Workhouse any such Lunatic, insane Person or Idiot for more than 14 days shall be deemed guilty of a misdemeanour.

Dangerousness, a tendency toward violence toward self or others, was the sole determinant for placement of lunatics outside the workhouse. If they were not

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[69]Nicholas C. Edsall, *The Anti-Poor Law Movement, 1834-44* (Manchester, England: Manchester University, 1971), 8.

judged to be dangerous, then they could continue to be housed in the workhouse. County asylums contained violent madmen; milder cases of lunacy could continue to be quartered in workhouses.

The distinction between dangerous and milder cases of lunacy is important if one hopes to disentangle the web of Poor and Lunacy Laws. The distinctions were confusing to those responsible for administering the laws. A clerk at Chesterton Union questioned the commissioners about whether a lunatic should have been sent to an asylum or kept at the workhouse. They answered:

> The Commissioners think, as a rule that the workhouse is not the proper place for lunatic paupers. The 9th George IV, c. 40, s38 points out the course which ought to be taken for the care and safe custody of insane persons who become chargeable to the parish, viz., by causing them to be conveyed to an asylum or licensed house under the order of the justices.
>
> But there may be cases in which some short delay must occur before the necessary order of justices can be procured, and the other arrangements made for the conveyance of such lunatics to an asylum. In these instances, it may be desirable for the security as well of the public as of the insane person, that the temporary admission of the latter into the workhouse should be resorted to. The 45th section of the Poor Law Amendment Act, however, forbids the detention of a dangerous lunatic in a workhouse for any longer period than 14 days: and the Commissioners on every ground, but as regards the lunatic and the other inmates of the workhouse, disapprove of the detention for any longer period than absolute necessity may warrant.[70]

The commissioners' statement makes it clear that lunatics were not expected to reside in workhouses for a substantial length of time. Several reasons account for the continued presence of lunatics in the workhouses. An insufficient number of county asylums had been constructed to care for all the luna-

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[70]*Official Circulars of Poor Law Commissioners*, II:49 (14 July 1842).

tics. Asylums also cost parishes over twice as much as workhouses.[71] Furthermore, some of the commissioners, notably Edwin Chadwick, believed that lunatics only required custodial care.

The 1834 Poor Law dealt inadequately with lunatics. The provisions of the law proved confusing, and needy lunatics were slipping through cracks in the system. Parliament recognized that the law was subject to abuse and required tinkering. Finances prevented an investigation and report until 1838. In that year, visiting justices, those responsible for inspecting outside the metropolitan area, reported to Parliament that there were some improvements but still many substantial abuses. In metropolitan areas, conditions were improving because county asylums and private madhouses were investigated more frequently than the provinces. Metropolitan asylums were inspected quarterly and provincial asylums were inspected semiannually. Commissioners found that conditions in metropolitan areas were improving; nevertheless, their report suggested that provincial care and maintenance of lunatics was "pitiable."[72]

Subsequent reports culminated in a recommendation from Lord Shaftesbury in 1844: only a national inspectorate could prevent abuses. In 1847, the Poor Law Commission was replaced by the Poor Law Board. Chadwick, a follower of Bentham, rose to prominence in England as commissioner of the Board of Health (1848-54). He opposed the construction of asylums because he thought housing lunatics in workhouse wards was more cost effective. The greatest good was not that the insane be maintained; instead, he believed rate

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[71]Arieno, *Victorian Lunatics*, 27.

[72]*Annual Report of the Metropolitan Commissioners in Lunacy*, 1838, BPP, IUP, sess. 56, vol. 6, 247.

reduction was more important. Depending on finances, between ten and twenty poor law inspectors were appointed. Two inspectors were responsible for poor law schools.

Outdoor relief was a feature of previous poor laws that was eliminated in 1845 for able-bodied laborers; it was supposed to be available only to the infirm, aged, and feeble. Because outdoor relief acted like a work subsidy for employers, wages were suppressed for able-bodied workers who were not on outdoor relief. Conservative implementation of outdoor relief was practiced in order to prevent malingering, that is, feigning impotence to avoid work, and to receive public largess.[73]

The 1834 Poor Law spoke directly to workhouses and poorhouses, not to asylums. The dangerous insane could reside in workhouses for no more than fourteen days.[74] By implication, though not explicit in the law, non-dangerous lunatics could be housed in workhouses. In 1838, Poor Law Commissioners sanctioned inclusion of lunatic wards in large workhouses.[75] Frustrated physicians complained about housing lunatics with able-bodied laborers in the workhouses. In 1842, the practice of housing non-dangerous lunatics in workhouses received legal approval.[76] In 1859, ten percent of the workhouses had lunatic wards.[77]

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[73]Bartlett, "The Poor Law of Lunacy," 56.

[74]*An Act for the Amendment and Better Administration of the Laws Relating to the Poor in England and Wales*, 1834, 4/5 William IV, c. 76, s. 45.

[75]Hodgkinson, *The Origins of the National Health Service*, 179-180.

[76]*Eighth Annual Report of the Poor Law Commissioners*, 1842, PP 1842 [359] xix 1 111.

[77]*Supplement to the Twelfth Annual Report of the Commissioners in Lunacy*, 1859, PP 1859 s. 1 (228) ix 1 9.

Changes Between 1835 and 1867

Two acts of Parliament were approved in 1845. The first established a national lunacy commission called "The Commissioners in Lunacy" whose jurisdiction was still the metropolitan area. They visited all metropolitan asylums and hospitals four times a year. In the counties, justices of the peace inspected asylums twice a year. All inspectors had authority to grant licenses for asylums and madhouses. Data from reports were due annually to the Secretary of State.

The Second Lunatics Act of 1845 made the erection of county and borough asylums compulsory. If the counties did not comply within three years, then the Secretary would require the justices to construct the asylums. Financing for the asylums was to come from a general tax collected from each county, administered by the county treasurer, and paid to the treasurer of the asylum. The government would also advance funds to counties that agreed to repayment from future taxes. This act further centralized government control over asylum construction and administration. Existing and new rules for asylums required the approval of the Secretary. This important act remained the legislative basis for regulating asylums into the twentieth century.

The quality of relief and treatment given to pauper lunatics after 1845 was inconsistent. The law's intentions was to protect society and lunatics. Their social welfare was assured by the Commissioners in Lunacy and local governments. Tension between the Poor Law Commissioners and the Commissioners in Lunacy caused conflicts that hindered care of pauper lunatics. They could not agree whether proper care was custodial or therapeutic.

> The real point at issue between the Poor Law authorities and the Lunacy authorities was the old one of cure or detention. If the county asylums were looked upon as curative institutions, then

> their high cost was justified and they had a legitimate grievance against the Poor Law authorities for refusing to send them pauper lunatics who were susceptible to treatment. If ... they were regarded merely as places of detention, the Poor Law authorities could rightly claim that they could do this work much more cheaply.[78]

In 1862, Parliament reaffirmed the provisions of the 1845 Lunatic Act.[79] Prior to this, English law contained no provision for voluntary committal to public asylums. This new act allowed for patients who were cured to stay voluntarily. This provision indicates that conditions were better for patients in the county asylums than outside them. The asylum provided for their basic needs — food, shelter, and clothing. It also provided a protected, structured environment. Peculiar behaviors were not ridiculed as they might be outside the asylum's confines. Residents had a predictable daily regimen. Thus, it is hardly surprising that some asylum residents chose not to leave. When this happened, payment was no longer to be paid by the parishes; instead, payment for pauper lunatics would come from a common union fund. Chronic lunatics were to be moved from their parishes to county asylums. Consequently, a large, measurable influx of lunatics into county asylums occurred.

By 1865, fifteen percent of the workhouses had lunatic wards.[80] In 1867, the Metropolitan Poor Act required that workhouses for the insane be constructed. [81] The Poor Law Amendment Act of 1867 empowered workhouses

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[78]Bernard Cashman, *A Proper House: Bedford Lunatic Asylum (1812 – 1860)* (n.p.: North Bedfordshire Health Authority, 1992), 91.

[79]*An Act to amend the Law relating to Lunatics*, 25 & 26 Vict. c. 111.

[80]David Mellett, *The Prerogative of Asylumdom* (London: Garland, 1982), 156.

[81]*The Metropolitan Poor Act, 1867*, 30 Vict. c. 6.

with formal committal powers.[82] Some lunatics were placed and maintained in workhouses by families who were not destitute. Pauper lunatics who were not a public menace were conceivably free to leave the workhouse just like any other pauper because provisions in common law allowed only dangerous insane people to be confined for the public's safety.

Summary

The fourteenth-century principle of *parens patriae* forms the basis for subsequent legislation to protect the insane. This protection eventually extended to their care, treatment, and maintenance. During the eighteenth and nineteenth centuries the confluence of philosophy, religion, and economics resulted in humanitarian reforms.

Foucault's *a priori* interpretation of history resulted in several inaccurate conclusions. Madmen did not replace lepers as objects of confinement. Nor was there a great confinement of the insane in England.

> But outside of the periods of crisis, confinement acquired another meaning. Its repressive function was combined with a new use. It was no longer merely a question of confining those out of work, but of giving work to those who had been confined and thus making them contribute to the prosperity of all.[83]

Confinement of the insane did not serve a repressive function. It was intended for protection on the one hand and for therapy on the other. Nor were asylums a repudiation of madness in an age of reason. There is no support in English legislation to accept Foucault's thesis that England felt threatened by the presence of insane people coexisting in a rational society in the Age of Reason.

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[82]Bartlett, "The Poor Law of Lunacy," 63-64.

[83]Foucault, *Madness and Civilization*, 51.

The titles of the legislation affecting lunatics contain phrases that demonstrate their benevolent intent:

- An Act for erecting Hospitals, or Abiding and Working Houses for the Poor;
- An Act for the better Relief of the Poor of this Kingdom;
- An Act for the safe Custody of Insane Persons charged with Offences;
- An Act for the better Care and Maintenance of Lunatics, being Paupers or Criminals in England;
- An Act for making Provision for the better Care of Pauper Lunatics in England;
- An Act to amend several Acts passed for the better Care and Maintenance of lunatics, being Paupers or Criminals, in England;
- An Act to amend the Laws for the Erection and Regulation of County Lunatic Asylums, and more effectually to provide for the Care and Maintenance of Pauper and Criminal Lunatics, in England; and,
- An Act to make better Provision for the Custody and Care of Criminal Lunatics.

In addition to the titles of Parliamentary acts, the words and actions of the reformers demonstrate their benevolent intent. Asylums were a natural outgrowth of the *parens patriea* doctrine. They safeguarded lunatics as much as they protected society.

Those following Foucault's path — Rosen, Szasz, and Scull — are building on a shaky foundation. Scull's theory that "moral treatment actively sought to transform the lunatic into something approximating the bourgeois ideal" lacks support.[84] Nor were the reformers constructing "fortresses of moral order ... in which were taught religion and whatever was necessary to the peace of the State."[85] The reformers' goals were far loftier: to ensure that madmen were treated humanely and with dignity insofar as they understood the implications of their philosophical and religious beliefs, their knowledge of science, and their conception of the English legal system.

> Before the pure spirit of benevolence and christian piety devised the foundation of charitable institutions for lunatics, these miserable objects were allowed to wander, and considered as interdicted persons — when they became troublesome or offensive they were shipt from tything to tything, and stockt, punished and imprisoned. The enlightened commiseration of modern philanthropists has afforded them every protection, as the existing public and private asylums sufficiently evince.[86]

A profound optimism characterized English legislation affecting the maintenance and treatment of mentally disordered people. This optimism resulted in a succession of legislative initiatives and failures between 1808 and 1862.

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[84]Andrew T. Scull, *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (Philadelphia: University of Pennsylvania, 1981), 111.

[85]Foucault, *Madness and Civilization*, 62.

[86]John Haslam, *Considerations on the Moral Management of Insane People* (London: n.p., 1817) in Porter, *Mind-Forg'd Manacles*, 313 n. 42.

Chapter 3

LIVING CONDITIONS OF LUNATICS

The end of the eighteenth century and beginning of the nineteenth century inaugurated a new, kind treatment of the insane. All lunatics, including paupers, benefited to some extent. Patients were considered to be sick people. rather than brutes or animals without human emotions or reason. Treatment providers began to encourage progress toward recovery by involving patients in work, bestowing human kindness on them, and involving them in entertainment as spectators or participants.

Some of the places where the insane could be found were nefarious, and others were refuges away from a harsh world. The poor and insane have always been mixed into society. With the increased concentration of people in cities, their visibility increased. Licensed houses, derogatorily called "madhouses," run for profit accommodated lunatics at the beginning of the nineteenth century. Conditions and care varied greatly among them. A few charitable asylums, like Bethlem and St. Luke's, accepted insane paupers. Workhouses also housed paupers suffering under mental afflictions. Many counties opened public asylums to meet the needs of the insane in their communities. Construction of asylums was an expensive endeavor for counties, and ratepayers already supported workhouses, infirmaries, and jails. Funding was raised through subscriptions, pledges of financial support by individuals and organizations.

Many families cared for their lunatic members at home because it was cheaper, and they often believed their loved ones received better care from

family members than strangers. Many insane people roamed the countryside when they had no family or relatives to care for them. If they were found by overseers for the poor, churchwardens, or justices of the peace, they could be detained in houses of correction, workhouses, infirmaries, or public asylums. Their county of residence, if it could be determined, was liable for expenditures associated with detainment; so, every effort was made to ascertain their former residence. When the lunatic had property or family members with property, the responsibility to pay for confinement rested on them. Many times the parish contracted with madhouses to care for lunatic paupers.

Pauper patients were the largest group confined to madhouses, county asylums, workhouses, and jails. Proprietors who took the parish's poor lunatics under contract infrequently gave therapeutic treatment, occupational therapy, recreation, or moral treatment. Although proprietors may not have deliberately practiced cruelty in their large warehouses of pauper lunatics, the general diet, exercise, and atmosphere were poor. Little thought was given to foster recovery because the warehoused human flotsam and jetsam were a source of income for the proprietors. Regarding the Select Committee of 1815, Glover summarizes their report, "It was still the case that very many patients were chained or manacled; it was common practice to starve them to reduce their strength."[1]

Irrespective of where patients received treatment, benevolent self-interest among the upper-classes and bourgeoisie determined the level of care. Treatment delivered to pauper lunatics was driven by conflicting motives: a desire to act charitably on behalf of the insane conflicted with avarice. On the

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[1]Glover, *The Retreat York*, 3.

one hand, the upper-classes and bourgeoisie wanted to provide for the basic needs of the insane; on the other hand, they did not want to spend money. Whatever was spent needed to do the most good for recipients and rate payers. Benevolent self-interest determined care and treatment.

Home Care

Families taking care of a mentally ill member would likely keep them hidden at home. Few could afford the luxury of expensive private asylums. Wealthy families might have a spare room, an attic, or a room off their home: usually a place out of the public's view or hearing with a caretaker to protect the family and their lunatic loved one. Many of the poorer classes did what they could to prevent a mischievous, crazed relative from wreaking havoc — often the lunatic was tied to a tree, chained out in the yard, or locked in the barn. Few families could afford to pay for asylum care. Conditions were often so terrible that lunatics were treated no differently than animals. Food and water were laid before them on a plate or bowl. Knives and forks were thought to be too dangerous for lunatics to use as eating utensils. Often they were ill-dressed or naked. Straw served as bedding. John Snow, the Royal Physician who popularized anesthesia by administering chloroform to deliver Queen Victoria's eighth child and who also demonstrated that cholera was transmitted by contaminated water, reminisced:

> I remember perfectly, as a youth, climbing the wall of a barn in order to look through a small grated window at a poor lunatic who, for over twenty-five years, had been chained in one corner of the place, and in that condition had been retained and kept by his relatives as a dog or other savage animal might have been. He was bedded down in straw just as other animals were, and, except that it was put for him on a wooden platter, his food was given to him as it might have been given to a dog. He took the food in his hands and tore it with his teeth, the idea being that it was not safe to let him have a knife or fork, or anything more

> than a wooden spoon as a help for feeding. The people who had this man in charge were not more cruel than the rest of mankind. They laboured under the idea that it was for the safety of themselves, and, on the whole, for the benefit of the insane man that he should be kept as he was kept. Had he been set at large he would have done some mischievous or dangerous thing for which he would have been punished, and for which they would have been responsible.[2]

This insane man's family kept him because they were held responsible for his mischief. Even when a lunatic posed an unbearable financial and emotional burden on his family, they could ill-afford the liability associated with allowing him to be unfettered. Untold deviltry could be inflicted on their neighbors and community that could render them destitute and homeless or jailed.

In the same narrative, Snow summarized the benefits of home confinement. Not only was the lunatic cared for by a family who ensured that he had regular, adequate meals, he was restrained from making mischief. He did not complain and did not pose an unbearable burden on the family. Mutual benefits were enjoyed by lunatic and family.

> ... He was not merely safe himself, but he was a safeguard to the lonely house or lodge attached to the barn in which he was domiciled. For strangely enough, the poor, helpless creature was a terror to the superstitiously wicked, to the prowling vagrant, the thief, the burglar, and the incendiary. When he howled or cried or laughed maniacally, the wicked were alarmed into flight.[3]

Hospitals For The Insane

General hospitals rarely had wards for the insane. If a patient were poor and physically or mentally ill, he might receive urgent, temporary care until a more suitable place could be found by the parish officer. For pauper lunatics, infirmary and hospital care was rare. Very few infirmaries could

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[2]Snow, "The First Advancement," 203-205.

[3]Ibid.

afford to add a lunatic ward or dispensary.

Bethlem Hospital

Criminal lunatics were sent to Bethlem, and in 1816 two blocks were added to the hospital. One block was set aside for men; the other, for women. These buildings were erected at public expense, and no financial liability was incurred by the charity. By 1838, the wards were full.[4] The name, Bethlem, struck fear in the minds of many. In *Barnaby Rudge,* Charles Dickens depicts the popular view of the horrors housed in Bethlem.

> A rumour had now got into circulation, too, which diffused a greater dread all through London, even than these publicly announced intentions of the rioters, though all men knew that if they were successfully effected, there must ensue a national bankruptcy and general ruin. It was said that they meant to throw the gates of Bedlam open, and let all the madmen loose. This suggested such dreadful images to the people's minds, and was indeed an act so fraught with new and unimaginable horrors in the contemplation, that it beset them more than any loss or cruelty of which they could foresee the worst, and drove many sane men nearly mad themselves.[5]

At the beginning of the nineteenth century, Bethlem Hospital, popularly identified as "Bedlam," had the worst name and most notorious reputation of any asylum in England. It was the oldest public asylum in London for the insane and one of the least able to adjust to the treatment revolution that was taking place with attitudes informed by "moral treatment." Bethlem lagged behind other institutions for several reasons. As an endowed hospital it did not compete for patients. It did not have funding problems like other institutions.

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[4]O'Donoghue, *The Story of Bethlehem Hospital from its Foundation in 1247,* 342.

[5]Charles Dickens, *Barnaby Rudge,* ed. Donald Lainson, 10 Nov. 1997 <ftp://beta.ulib.org/webRoot/Books/_Gutenberg_Etext_Books_NEWEST/etext97/rudge10.txt>.

Bethlem was exempt from the Madhouse Act of 1815, a privilege for which the hospital annually paid £600. Furthermore, Bethlem claimed it had ancient privileges. The hospital refused to be registered by the Lunacy Commissioners until 1853. For generations, members of the Monro family superintended the hospital. Because Bethlem was not a teaching hospital, it did not bring in young physicians with modern, reforming ideas. The entrenched mind-set of Thomas Monro and John Haslem was that Bethlem provided custodial care.

Bethlem Hospital had been run by the same family for generations. Dr. Thomas Monro continued to use the modes of treatment that had been passed down in his family: corporal punishment, restraints using irons, manacles, and chains. The custom of bleeding, purging, vomiting, and bathing patients was practiced. Medicine was administered if needed, though not depended on, by the staff.

> I do not think medicine is the sheet-anchor (*sic*); it is more by management that those patients are cured than by medicine.... The disease is not cured by medicine, in my opinion.[6]

Medical treatment was adjunctive rather than curative; that is, treatment was administered as required to control the patient. When patients were violent, for example, they could be bled or purged until weakened.

In 1814, Edward Wakefield, a philanthropist, toured and inspected asylums throughout England. Wakefield visited Bethlem where he documented ghastly conditions: naked women shackled to the walls, inadequate supervision and treatment of patients, outdated treatments that left patients physically weakened, drunken and incoherent staff, and extensive use of physical restraints. Wakefield met William Norris, an American patient suffering from

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[6]PP 1814 – 15 (296) iv 805.

tuberculosis, who had been chained for twelve years. Norris's weakened condition was so bad that he could not have injured anyone or escaped. Wakefield reported his findings to Parliament's Select Committee that was investigating the care of lunatics. This focused public attention on Bethlem's conditions.

> [He] had about him a weight of iron, six or eight-and-twenty pounds...confined to his bed without being able to turn round for nine years, or without being able to get out and sit on the edge of his bed, being chained by the head by a chain only twelve inches from the iron stantion.[7]

The subsequent investigation by Parliament resulted in mental health treatment reform.

At a Select Committee hearing investigating the allegations, considerable information was revealed about how the hospital was operated. Monro's testimony indicated that he attended the hospital about three times a week. During these visits, he inquired about the welfare of the patients but did not always walk through the hospital to see each one. He walked through the hospital a few times a month depending on circumstances and examined patients' mental derangement and bodily health.

Haslam, the apothecary, administered the hospital in Monro's absence and gave orders. When Haslam was asked about distribution of medicine to patients, he indicated that during the summer months medicines were administered to males and females but not to incurables. During the winter, Haslam said that it was too cold to administer medicines. Physically fit, violent patients were treated with bleeding, purging, baths, and vomiting when it was deemed helpful. Though Haslam conducted day to day tasks, Monro assumed responsibility for overseeing his apothecary and operating the hospital. Monro

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[7]PP 1814 – 15 (296) iv 804.

would often discuss the treatment of patients with Haslam during his rounds. Violent and furious patients were identified for more frequent purging and bleeding.

Under questioning, Monro admitted that he would never use chains in his private house and that chains are appropriate to restrain paupers.

> Do you know the number of persons now under restraint in Bethlem, in irons?—No; I have nothing in the world to do with the irons; I never gave an order for a patient to be put into irons in the whole course of my life.
>
> What are your objections to chains and fetters, as a mode of restraint?—They are fit only for pauper Lunatics; if a gentlemen was put into irons, he would not like it.
>
> You have stated, that chains and fetters are fit only for pauper Lunatics; what do you mean by that answer?—I mean that pauper lunatics of course cannot pay for the regular attendance to prevent their doing mischief; and there are so few servants kept for the purpose, that it is the only mode of restraining them.
>
> Have you any objection, in a medical point of view, to the use of chains and fetters as a mode of confinement?—I conceive chains and fetters are fit only for those persons who are excessively furious and violent, and that require a great deal of attention and care, for fear they should do themselves mischief, or any other persons; and in a hospital there is no possibility of having servants enough to watch a great number of persons, without irons; therefor I conceive it is proper in a hospital, though not in a private house; I consider a strait-waistcoat a much better thing than irons.[8]

Monro confessed he saw no other way to control an excessively furious and violent patient. He thought a strait-waistcoat would be better than irons in the daytime but that at night in the winter patients would not be able to help themselves. In the winter lunatics might be put to bed at 4:00 p.m. until 6:00 or 7:00 a.m. the following morning. Patients in strait-waistcoats were

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[8]*Report Together with the Minutes of Evidence Taken Before the Select Committee Appointed to Consider the Provision Being Made for the Better Regulation of Madhouses in England*, 1815, PP 1814 – 15 (296) iv 801.

subjected to other inconveniences: the inability to scratch, to swat annoying flies, and to breathe freely. The degree of tightness depended on the attendant who tightened it.

Other insights from Monro's testimony included information about the common treatment of patients. Outrageous patients were mixed with quiet ones during the daytime. Rowdy patients were chained to the walls and the quiet ones left to wander through the dayroom and side rooms. He believed that mixed patients might recover more slowly but the benefit might be a patient who recognized the folly of others. No activities were planned for the patients.

Finally, the committee hearing focused on the case of William Norris. Monro recalled that he was a "very ferocious mischievous madman" whom he visited often. Monro remembered that Haslam believed that loosening Norris's restraints would be unwise because one of his keepers overheard him threaten to murder someone. Monro claimed that he frequently asked Haslam if the quantity of iron used on Norris could be lessened but left the decision to his apothecary.

> [Haslam always] mentioned to me that there would be mischief, and that I should be responsible for any accident in case it should happen; I did not like to have that sort of responsibility upon my shoulders. The man was so extremely prone to mischief, even a look would sometimes irritate him to such a degree.[9]

When asked if lack of comfort further irritated Norris, Monro claimed that he was unaware that more comfort would have made a difference.

> He seemed to me to be a most insensible man, little better than a brute, he had not the least feeling whatever. I do not recollect that I ever heard him complain of the fetters he was confined by;

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[9]Ibid, 804.

> he was perfectly lost to all sensibility whatever... I mean all feeling. All feeling of mind too; he appeared to me to have lost his mental feeling entirely.[10]

Caretakers in asylums did not treat patients humanely. Norris came to represent the extreme misery and inhumanity that one person could endure in Bethlem. Conolly observed that people charged with caring for lunatics could become callous; consequently, patients suffered.

> Indeed it would almost seem as if, at the period from the middle to near the end of the last century, the superintendents of the insane had become frantic in cruelty, from the impunity with which their despotism was attended.... People not naturally cruel became habituated to severity until all feelings of humanity were forgotten.... But men's hearts had on this subject become gradually hardened. In medical works of authority the first principle in the treatment of lunatics was laid down to be fear, and the best means of producing fear was said to be punishment, and the best mode of punishment was defined to be stripes.[11]

Disclosures about the abuses in Bethlem assumed a human face in Norris. Families and the public were not allowed access to patients; so, rumors and mythology abounded about Bethlem that assumed the stature of bogeymen and ghouls. When word about Norris was leaked, people readily identified with his mistreatment and reacted with universal abhorrence.

In 1815, public outrage accompanied disclosure about Norris. He became a cause célèbre. Norris came to embody the harsh treatment dispensed in the wards. Maltreatment of the mentally ill, which had been vaguely abstract in the public's mind, became personified. The Norris case was not exceptional. Norris's scandalous poor treatment may have been taken for granted by the asylum administration; it was not taken for granted by the

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[10]Ibid, 805.

[11]John Conolly, *The Treatment of the Insane Without Mechanical Restraints* (London: Smith, Elder & Co., 1856), 12-13.

public. A Parliamentary inquiry into the case and the general care and treatment of Bethlem's patients resulted in condemnation. Exposure to the Norris case offended the public and spurred legislative reformers. Thirteen years later Sir Andrew Halliday observed that progress had been made but substantial improvements remained to be made.

> [Bethlem Hospital] is now well conducted, and the patients are humanely and judiciously treated; but it has still too much of the leaven of the dark ages in its constitution, and too rigid a system of quackery is maintained, in regard to its being seen and visited by respectable strangers, and there is too little space for exercise and employment, for it ever to prove an efficient hospital.[12]

Bethlem Hospital remained a custodial care facility with neither workshops for manual labor nor amusements for patients. The hospital lacked adequate room to expand and staff to supervise patients; moreover, it was exempted from legal requirements because of its age and standing as a royal hospital. Halliday alluded to an old practice of displaying Bethlem's agitated patients for entertainment.

> Bedlam became one of the sights of London; young men would take their girl-friends there of (sic) a Sunday to be diverted by the maniacs, for a charge of 2d per head. If the patients were withdrawn or lethargic, the keepers would prod them with sticks to enrage them so that their betters could have their money's worth of fun.[13]

Another function of Bethlem was to take criminal lunatics, those confined under court order, starting in 1816. They were housed in a wing separated from other patients. The criminal insane were prone to violence so moral

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[12]Pliny Earle, *A Visit to Thirteen Asylums for the Insane in Europe; To Which Are Added A Brief Notice Of Similar Institutions In Transatlantic Countries and in the United States, and an Essay on the Causes, Duration, Termination and Moral Treatment of Insanity with Copious Statistics* (Philadelphia: J. Dobson, 1841), 65.

[13]Glover, *The Retreat York*, 2.

therapy was avoided: employment of patients and elimination of physical restraints were not welcomed. Because of overcrowding at Bethlem, many criminal lunatics were transferred to Fisherton House, Salisbury, and elsewhere. Most asylums were not happy to have criminal wards attached. It was much harder to attract new clientele if criminal lunatics were maintained; after all, what family wants a member who is mentally ill exposed to or kept near violent criminals? By 1863, Broadmoor Hospital for the criminally insane opened and Bethlem's criminal population was transferred there.[14]

About the same time as the Parliamentary revelations about abuses in Bethlem became part of the public discourse, Tuke published his work about York Retreat and Pinel's work was translated into English. The path was laid for humane treatment and reforms.

Hospital Treatments

Treatment of the insane was derived from humoral theories dating back to Greek and Roman times. Attempts to cleanse the body of bad humors included cupping, blistering, purging, diuretics, bleeding, and a variety of chemical compounds. Cupping was a treatment in which evacuated glass cups were applied to the skin to draw blood toward or through the surface. Blistering was a process whereby blisters were created with hot irons applied to the skin. Purging evacuated a patient's bowels to free him from impurities. Diuretics were compounds that increased a patient's discharge of urine. Bleeding or bloodletting involved the therapeutic removal of a patient's blood. Each of these techniques was based on a belief that mental illness was caused by an

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[14]O'Donoghue, *The Story of Bethlehem Hospital from its Foundation in 1247*, 345.

imbalance in bodily fluids, and identical or similar practices to relieve the imbalance can be found in the therapeutics of Hippocrates and Galen.

The physical condition of lunatics when they were transferred for medical care was often critical. To relieve their symptoms they had been treated to the verge of death.

> Bleeding and purging were acceptable treatments both in the asylum and within general practice. Leeches were still being purchased as late as 1848. The condition of many admissions was quite appalling, many having bled almost to death.... '[Many] have been rendered incurable either by neglect or the improper treatment of excessive bleeding and general depletion. Several have been sent here in such a state of emaciation and debility that in a few days, nay even in a few hours, death has closed the scene.'[15]

Preparations given as treatment to lunatics could hardly have left them in good physical condition. Tarter emetics, strychnine, crude opium, arsenic and creosote mixed with wine, the "proto-chloride of mercury," and tartarized antimony could be repeatedly administered to alleviate symptoms of lunacy.[16]

Surgical procedures might be performed on chronic patients. An incision might be made through the scalp. A seton – a thread or tape imbedded in the skin at the nape of the neck – would be implanted with its end protruding to draw out bodily discharges.[17]

Patients could be stimulated for therapy. Patients were sometimes vigorously washed with stiff brushes. Hot towels were forcibly rubbed on the skin to give the skin a bright red flush. Intense exercise exhausted manic patients.

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[15]A. L. Ashworth, *Stanley Royd Hospital: Wakefield, One Hundred and Fifty Years, A History* (n.p.: n.p., 1975), 27.

[16]Gertrude Smith, *The Old Manor Hospital: Salisbury Wiltshire* (n.p.: n.p., 1978), 16.

[17]Ibid., 16.

Hydrotherapy was employed: manic patients would be dunked in cold baths and melancholy patients, in hot baths.

"The long stocking quietener" was used to control uncooperative patients by inducing a state of near suffocation. An attendant twisted a long stocking around a patient's neck until he was temporarily asphyxiated and insensible. Then another attendant dressed the semi-suffocated patient for the day.[18]

A popular device was the use of a spinning chair or table developed by Erasmus Darwin. Its centrifugal force was so great that incontinence or hemorrhage could result.

> The centrifugal and the centripetal treatment on a wheel were other methods followed out for the management of the insane up to the latter part of the period preceding the Victorian. It had been ingeniously surmised that the amount of blood supplied to the brain could be increased or lessened by placing a living human body on a horizontal plane attached at a right angle to its axis on a large revolving wheel. If the head of the sufferer were placed on the circumference of the wheel, then it was assumed that the blood in the body would be forced into the brain as the wheel went swiftly round; if, on the contrary, the sufferer were placed with the head to the centre and the feet to the circumference, the brain would be emptied of blood as the wheel revolved. One of the medical friends of my early days saw this machine in action, and made inquiries as to the effect it produced. His record in respect to it was, that, if the prayers of the sufferers not to be put upon it, their screams on it, and their giddiness and sickness when they came off it, were to be accepted as signs of improvement, then the treatment might be considered to have been of value.[19]

The device spun up to one hundred times per minute. The patient reclined when sleep was desired and was erect to stimulate the intestines.[20] The terror

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[18]Snow, "The First Advancement," 209.

[19]Ibid., 207.

[20]Conolly, *The Treatment of the Insane Without Mechanical Restraints*, 14-15.

of patients subjected to this treatment suggests that, despite the good intentions, this device, like hot irons, was more appropriate to the torture chamber than medical treatment. No evidence of lunatics cured by this device can be found.

These medical and surgical treatments were acceptable and in accordance with the medical practices of the time. Fortunately for pauper lunatics, few of the large madhouses or county asylums could afford such "extravagant" treatments; instead, unruly patients were secluded or restrained.

Asylums: Private, Public, and County

Charter for Asylums

The need for residential treatment was great, and the available facilities were few. Private asylums were homes or manors often run for profit by offering custodial care for lunatics. Residential treatment was hard to get. Overcrowded conditions resulted in long waiting lists for admission to asylums. Very few people were released because care was custodial rather than therapeutic. Construction of an infrastructure to care for lunatics could not keep pace with the influx of people caused by urbanization and industrialization. This resulted in outrageous living conditions in asylums that required government regulation.

Private asylums were known as "madhouses." This term was derogatory and was used because these asylums were held in low esteem. Stories of involuntary committals, miserable conditions, and filth characterized many private asylums, especially the ones that contracted with parishes to accept the insane poor. Lunatics were placed in private asylums for custodial care, not treatment. Madhouses had a bad reputation among the facilities that

served the mentally ill. The expression, "trade in lunacy," was used of unscrupulous businessmen who cut their expenses at the cost of their tenants. Scathing remarks can be found in almost all the literature of the time.[21] Despite generally dreadful reputations, some private asylums—like York Retreat—provided extraordinary care for residents.

Private Asylums were also known as "licensed houses" because when at least two lunatics were housed in one, a license was required. The 1774 Act for Regulating Madhouses required that every person confined to a private asylum be properly certified as "insane." It also required that proper care and medical attention would be given to each patient. These laws were enacted to prevent widespread abuses. The 1774 Act that regulated private asylums did not have the necessary resources to enforce the regulations. Before 1845, five Fellows of the College of Physicians were empowered to grant licenses for public and private asylums. They visited these institutions if they fell within seven miles of London. In the countryside, these duties fell to the justices of the peace and a physician. The justices of the peace were nominated at Quarter Sessions.[22] A history of English laws regulating asylums is given in the previous chapter.

Smaller madhouses were sometimes owned by physicians who volunteered at dispensaries, hospitals, or workhouses. Frequently the physician also provided care at the county asylum. Most proprietors had no medical training or qualifications. They usually had a high ratio of attendants to

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[21]William Llywelyn Parry-Jones, *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London: Routledge and K. Paul, 1972), 184.

[22]Cashman, *A Proper House,* 3.

patients. Anywhere between two people and three hundred people lived in a facility depending on the size of the building. Private asylums often specialized: some took only women, some took imbeciles.

Private asylums, which began to flourish around the beginning of the nineteenth century, thrived as the need for accommodations for the mentally ill multiplied later in the century.

> One of the origins of the madhouse system, at least so far as pauper lunatics were concerned, was the practice which developed in some parishes from the mid-seventeenth century onwards of boarding them out, 'at the expense of the parish, in private dwelling houses, which gradually acquired the description of "mad" houses'.[23]

The few restrictions and regulations of licensed houses were difficult to enforce. No restrictions were imposed on the number of patients a single proprietor could house. Madhouses that took paupers tended to keep a substantial quantity of them so they could make a profit because paupers were less profitable than other patients. The goal of parishes when they contracted with private houses was to minimize costs to ratepayers.

The practice of buying an old manor house and converting it into an asylum to care for the insane seems to have been possible for anyone who had the means and desire. Owners were not required to have any medical experience. Often they gave the well-to-do rooms in the house, and the others resided in converted stables. Deliberate cruelty may not have been practiced in all these large warehouses of the poor; however, "patients in madhouses were [frequently] subject to beatings and cruelty."[24] The amount of cruelty was probably in proportion to the force required to control patients and the

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[23]Scull, *Museums of Madness*, 25.

[24]Glover, *The Retreat York*, 3.

ratio of caretakers to patients. Little was done to aid their recovery because they were a source of income to the madhouse proprietors.

A report given to the Select Committee of 1815 by Edward Wakefield, a visiting commissioner, was disturbing. He testified that pauper patients were customarily leg locked or arm locked at night to their beds to keep them calm. The beds were shaped like troughs and filled with straw. During the day, the troughs were stood on end to be emptied, dried, and aired out. He also observed that paupers were locked out of their quarters and kept in yards during the day.

> I apprehend, that in winter time, when they are obliged to be under cover, the day-rooms must be excessively crowded; from the view which I had of it, my opinion is, that the treatment is as good as the man is capable of giving to such person in such a building....[25]

From another establishment, he described the patients who were locked outside in fresh air. They were huddled together in one mass like a flock of sheep. Wakefield contrasted houses that kept affluent patients.

> At this establishment there are very large gardens; some of the patients pay rather liberally; and in those gardens are many small distinct houses, and I wish to draw the attention of the Committee to the great benefit of these distinct houses; the great enjoyment which a patient who has the means of paying for it, receives from living in a small house, surrounded by a garden, without the noise or the annoyance of violent maniacs about him.[26]

> To describe every private house would be impossible. Some owners were

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[25] J. Mortimer Granville, *The Care and Cure of the Insane: Being the Reports of the Lancet Commission on Lunatic Asylums, 1875 – 6 – 7, For Middlesex, the City of London, and Surrey with a Digest of the Principal Records Extant and a Statistical Review of the Work of Each Asylum from the Date of its Opening to the End of 1875* (London: Hardwicke and Bogue, 1877), 31.

[26] Ibid, 32.

"good fatherly types," and others were despots. Proprietors were known to refuse to allow an inspection because "an inspection of that house would be signing its death warrant."[27] Life expectancy of paupers in madhouses was worse than for private patients. Actuarial studies of statistics accumulated by the Lunacy Commissioners showed that pauper lunatics housed in Metropolitan licensed houses had a higher mortality rate than private patients. Between 1833 and 1839, 947 pauper lunatics died in licensed houses compared to 557 lunatics who were not paupers. During this same period, 2,939 paupers were admitted and 2,417 non-paupers.[28] Although 21.6% more paupers were admitted to licensed houses, 70.1% more deaths occurred among the paupers.

Persistent pressure from reformers and published reports about paupers in madhouses compelled Parliament to pass a law that required local justices to establish county asylums at the ratepayers' expense. One reformer, Magistrate Godfrey Higgins, documented the unspeakable squalor at the York Asylum in letters to newspapers. He discovered horribly filthy hidden cells, "Augean Stables,"[29] occupied by poor, insane women. Previous inspectors conducted superficial visits to the quarters of the affluent and reported satisfactory conditions. They had not sniffed out the stench of the paupers. He hoped these would be cleaned thoroughly with the public's pressure.[30] Sustained, likeminded efforts by many concerned citizens improved the lot of pauper

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[27]Ibid, 31.

[28]Ibid, 37.

[29]Augeas was a legendary Greek king who did not clean his stables for thirty years.

[30]Anne Digby, *From York Lunatic Asylum to Bootham Park Hospital*, Borthwick Papers, no. 69 ([York]: University of York, 1986), 18-19.

lunatics by 1862. With the opening of county asylums, insane paupers were transferred to the new institutions.

> More licensed houses disappeared between 1850 and 1860, the decade during which most county asylums built under the 1845 Asylums Act first opened their doors, than during the next thirty years; and those that disappeared included all the largest houses.[31]

The existence of county asylums put pressure on workhouses to transfer insane paupers to them. The effect was immediate and dramatic.

Before 1828, the system for the inspection of private asylums was fundamentally flawed. No penalties were imposed for non-compliance; only warnings were distributed. Evidence presented to the Select Committee in 1815 and 1816 delineated the scope of this problem. It found that the Act of 1774 lacked teeth. The proprietors could lose their license if they refused to allow inspection by commissioners; nevertheless, licenses were rarely rescinded once issued. The commissioners could report abuses when they documented them but could not force proprietors to improve care. Many reformers—such as Lord Ashley, Sir George Onesiphorous Paul, and Samuel Whitbread—labored to enact legislation to correct egregious forms of cruelty in madhouses.[32]

Thirty-five establishments licensed to care for the insane were under the jurisdiction of the Metropolitan Commission in 1828. The establishment of full-time Lunacy Commissioners in 1845 did much to protect the interests of private patients. Before 1845, the Commissioners, all physicians, were part-time, unpaid workers. The new Commission constituted a permanent, full

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[31]Scull, *Museums of Madness*, 53.

[32]Glover, *The Retreat York*, 3.

time inspectorate. Five lay, three medical, and three legal commissioners comprised the Commission. The lay commissioners were unpaid. The other six commissioners were paid £1500 annually. They were prohibited from holding any other positions. The duty of inspecting, licensing, and reporting was extended permanently to cover all licensed houses and hospitals in the country. Parliament specified clearer guidelines for certifying lunatics. Institutions that treated the insane were required to maintain detailed admission and treatment records.

By 1845, only eighteen county asylums had been constructed. Administrators underestimated the needs, and applications for admission soon outnumbered beds. The problem of overcrowding and long waiting lists continued to be the rule rather than the exception.

> These circumstances, along with increased urbanisation (*sic*) and other factors dictated that extensions should be built [at Stanley Royd Hospital], the first of which was in 1829. Throughout the century further massive extensions were found necessary, and what had at first been an attractive, symmetrical Georgian building proliferated until by the end of the century it accommodated no fewer than 1,469 patients; requirements for accommodation in asylums was certainly growing for in the intervening years two further asylums ... had been built to provide for the needs of the southern and northern extremities of the Riding.[33]

Many asylums maintained class distinctions. Well-behaved upper class convalescents were not controlled by coercion. They were often allowed the best apartments on the grounds and had personal "airing space," an area where they were allowed to breathe fresh air and bask in the sunlight. Paying patients in public and private asylums were given more food to eat, books to read, and other amusements. The bourgeoisie also fared better. Recovery was

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[33]Ashworth, *Stanley Royd Hospital,* 11.

encouraged through recreation and employment in their vocations. The poorer classes often could not afford the prices of a public or private asylum. Many lower-class families could become destitute if long stays were required. When families could not afford to keep loved ones in private or public asylums, they would be transferred to pauper county asylums. It was axiomatic that class-consciousness tended to affect patient treatment; however, notable exceptions can be found. For example, King George III's treatment at Willis's hands was unusual for a member of the aristocracy and even more so for a sovereign.

The wealthy could afford to send mentally ill relatives to private asylums; although, records can be found of parishes sending paupers to some of the larger private establishments for little more than the cost of custodial care. The institutions were administered by representatives of ratepayers, and members of county and borough councils under provisions of acts of Parliament.[34] Thus legislation was enacted nationally and implemented locally. On admission of a lunatic to a private asylum, notification was required to be sent to the Commissioners informing them that the lunatic was being properly treated under the supervision of a physician, apothecary, or surgeon.[35] The Lunacy Commissioners sent annual reports to the Select Committee who forwarded them to the Lord Chancellor. New parliamentary legislation was enacted as needed.

Licenses were difficult to rescind. As a matter of practice, they were renewed annually. Failure to comply with minimal standards of care resulted

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[34]England Mental Hospitals' Association, *Thirty Years' Administration of the Public Asylums in England & Wales* (London: Hodder and Stoughton, 1992), 1.

[35]Glover, *The Retreat York*, 92.

only in suggestions for improvement, never fines or revocation of licenses. Magistral supervision of private asylums was difficult. The magistrates had no particular guidelines to follow nor were they given instructions about what they should investigate or require except regarding sanitary conditions and prayers. Proprietors were to encourage religious observances and prayers among their charges. When magistrates and proprietors had personal relationships, inspections were frequently superficial. Magistrates frequently sympathized with the difficulties faced by proprietors. Magistrates not only understood the challenges of running a licensed house, but also would not want to deprive a proprietor of his livelihood.[36] They understood the small profit margins and grasped that without a license the proprietors would have been put out of business. Not only would this hurt the proprietor, but such radical action would displace the lunatics and damage communities. The unwillingness of country gentlemen to perform their duty allowed many abuses to continue unabated. In his concluding comments to the Select Committee, Mortimer Granville discussed the difficulties faced by the magistrates.

> In closing the account which I have given of houses of this sort within the Bills of Mortality, I beg to say, that I have been received with great civility by many keepers of Private Houses, and the public institutions of Saint Luke's and Guy's Hospitals; and that the general feeling which I have upon the subject is, that there is great merit due to many individuals for the humanity which they exercise to the unfortunate persons under their care; and that I should be very much hurt, if any observations that I made in any place should tend to injure the character of the business of a keeper of a Madhouse.[37]

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[36]J. A. R. Bickford and M. E. Bickford, *The Private Lunatic Asylums of the East Riding* (n. p.: East Yorkshire Local History Society, 1976), 11.

[37]Granville, *The Care and Cure of the Insane*, 32.

Asylums as Self-Contained Refuges

York Retreat is a watershed in the treatment of lunatics. The success of the York Retreat's moral treatment benefited the patient and the asylum. York Retreat allowed patients, within their capabilities and interests, to do diverse work. Allowing patients to engage in familiar occupations or to be employed to their limits proved therapeutic and gratifying. Patients regained self-confidence and esteem. York Retreat also treated patients with consideration and respect. Earlier asylums were characterized by cruel and arbitrary exercise of power, and excessive force to avoid losing control over inmates. Patients, once confined to wards and left to themselves, were allowed outside to work and contribute to a community. The importance of employing the patient's body and mind exemplified treatment in the York Retreat. The success of moral treatment there became a paradigm for the administration and conduct of later asylums. The transition to moral treatment was not immediate. Time was required for existing asylums to accept moral treatment and evolve their practices.

The insane were believed to have superhuman strength when they became agitated or excited. Attendants were expected to control patients under their charge. The ratio of attendants to patients could vary among asylums. For example, in the York Asylum, across the district but in the same county as the more famous York Retreat, one attendant was often assigned to as many as twenty-five patients; in the Retreat, the ratio was one to ten. The York Retreat's success resulted from Enlightenment concepts of man's dignity. The administration encouraged patients to engage in work and treated them humanely.

The Retreat originated in a tragedy that precipitated constructive

grassroots action. William Tuke was incensed by the inhumane treatment of a young woman belonging to the Society of Friends. After becoming mentally ill, she was placed in the York Asylum where she was not allowed to have any visitors. At the time, this was part of the usual treatment of the insane. She subsequently died. Among the Quakers, strong suspicions arose that she had been ill treated or neglected. Private donations by fellow Friends raised the funds necessary to establish York Retreat. The use of the term "Retreat" was intended to convey that the facility was a quiet haven.

> In short, the patient was given no excuse for feeling that his mental condition precluded participation in normal human activity, or cut him off from the outside world.[38]

Foucault and his followers, however, believe that the function of York Retreat was to imprison crazed minds as well as segregate them from society. Foucault assesses Tuke and the York Retreat by turning a straightforward reading of history topsy-turvy.

> We must therefore reevaluate the meaning assigned to Tuke's work: liberation of the insane, abolition of constraint, constitution of a human milieu — these are only justifications. The real operations were different. In fact Tuke created an asylum where he substituted for the free terror of madness the stifling anguish of responsibility; fear now raged under the seals of conscience. Tuke now transferred the age-old terrors in which the insane had been trapped to the very heart of madness. The asylum no longer punished the madman's guilt, it is true; but it did more, it organized that guilt; it organized it for the madman as a consciousness of himself, and as a non-reciprocal relation to the keeper; it organized it for the man of reason as an awareness of the Other, a therapeutic intervention in the madman's existence. In other words, by this guilt the madman became an object of punishment always vulnerable to himself and to the Other; and, from the acknowledgment of his status as object, from the awareness of his guilt, the madman was to return to his awareness of himself as a free and responsible subject, and consequently to reason.[39]

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[38]Jones, *Lunacy, Law, and Conscience 1744 – 1845*, 62.

[39]Foucault, *Madness and Civilization*, 247.

For Foucault, Tuke imprisoned maniacs mentally rather than physically. This bondage was more pervasive, insidious, and effective than any physical restraints. Despite Foucault's assertions, his perspective of history is unsupported by events. Residency at York Retreat was voluntary and, in it ally, it was open only to Quakers. Tuke's intention was clearly not to enslave maniacs nor to manipulate them. He acted because madmen were being abused. The immediate cause for Quakers to unite in the creation of the York Retreat was the suspicious death of a Quaker madwoman. They created a refuge for the insane. Tuke and the Quakers were motivated by religious convictions and not pecuniary interests. They applied their religious beliefs to address a social evil: outrageous treatment of lunatics. Personal responsibility, work, and respect formed the basis for moral therapy's care of lunatics. These values grew directly from Christian theology and values. Caretakers were not solely responsible for their patients. Lunatics could contribute to their own care, condition, and well-being. When patients were not treated like mindless brutes, a bath, change of clothing, and good meal changed their dispositions. Foucault acknowledges this:

> Samuel Tuke tells how he received at the Retreat a maniac, young and prodigiously strong, whose seizures caused panic in those around him and even among his guards. When he entered the Retreat he was loaded with chains; he wore handcuffs; his clothes were attached by ropes. He had no sooner arrived than all his shackles were removed, and he was permitted to dine with the keepers; his agitation immediately ceased; "his attention appeared to be arrested by his new situation." [40]

Four months later, this maniac was considered cured and was released. What Foucault asserts to be mental bondage, was a curative. Lunatics without hope

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[40]Ibid., 245-246.

of cure were often helped by humane treatment. Instead of spending years in conditions ill-suited to animals, patients were free to leave York Retreat and resume a normal life. Clearly, Tuke's intent was not to place the insane into bondage. Many insane individuals were cured at York Retreat and rejoined society. The remainder were maintained in conditions far superior to what other lunatics endured. Moreover, Foucault does not offer any alternatives to moral treatment that proved to be either efficacious or dignified. Tuke offered the insane hope and dignity that would have been impossible while confined in prison, wandering the countryside, stealing food, or being abused.

The consequences of contrived interpretations can be illustrated with a cautionary tale. Oliver Sacks, one of the twentieth century's greatest medical chroniclers, recounts a case history in a story entitled "The Last Hippie." It is about a young man full of promise and idealism who drops out of college to join the Hari Krishnas. An earnest devotee, he complained that his vision was growing dim. His swami and others interpreted spiritually, "He is becoming enlightened. His inner light is growing."

> His sight grew still dimmer, but he offered no further complaints. And indeed, he seemed to be becoming more spiritual by the day — an amazing new serenity had taken hold of him. He no longer showed his previous impatience or appetites, and he was sometimes found in a sort of daze, with a strange (some said "transcendental") smile on his face. It is beatitude, said his swami — he is becoming a saint. The temple felt he needed to be protected at this stage: he no longer went out or did anything unaccompanied, and contact with the outside world was strongly discouraged.[41]

The cause of his spirituality and other-worldliness was a brain tumor that grew to be the size of an orange or grapefruit over a couple of years. It

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[41]Oliver Sacks, "The Last Hippie," *An Anthropologist on Mars: Seven Paradoxical Tales* (New York: Alfred A. Knopf, 1995), 44-45.

destroyed the pituitary gland, optic chiasm, and portions of the temporal lobes. He was left hairless, with the plump appearance of Buddha, blind, and gravely disabled neurologically and mentally. His condition was completely avoidable because the tumor was benign and operable. "If medical sense, and even common sense, been allowed to judge his state" this tragedy could have been prevented.[42] Foucault's revisionism can be compared with the swami's interpretation: both fail the common sense test. Foucault's interpretations of Tuke and moral treatment are like the swami's interpretation of the young man with a brain tumor approaching nirvana.

Foucault was not concerned with common sense. Nor did he seek to understand how the present emanated from the past. He used history to diagnose the present.[43] Foucault was concerned with how power was wielded. According to Foucault, "My objective ... has been to create a history of the different modes by which, in our culture, human beings are made subjects."[44] Foucault's *Madness and Civilization* applied this agenda to society's relationship to lunacy. As a result of this presupposition and his skepticism, Foucault attributed sinister motives to Tuke and other reformers that disregarded their statements and intellectual milieu. He superimposed his Marxist and Nietzchean concept of power when selecting and interpreting historical events and their contingencies. The founding of York Retreat was the result of benevolent self-interest goaded by the death of a young Quaker woman.

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[42]Ibid., 46.

[43]N. Rose, "Of Madness Itself: *Histoire de la Folie* and the Object of Psychiatric History," *History of the Human Sciences* 3, no. 3 (1990): 373-80.

[44]Michel Foucault, "The Subject and Power," in *Michel Foucault: Beyond Structuralism and Hermeneutics*, Hubert L. Dreyfus and Paul Rabinow (Chicago: University of Chicago Press, 1982), 208.

Tuke was not directly influenced by Pinel who independently introduced the non-restraint method of treating the mentally at Bicêtre and Salpêtrière between 1792 and 1794. Nor was he influenced by Pinel's *Treatise on Insanity* that was first published in 1801 and translated into English in 1806 by David Daniel Davis. Tuke and Pinel were widely heralded throughout Europe for their innovative, successful treatments. Tuke's moral therapy was a product of his humanitarianism and Christian beliefs.

> Although Evangelicals emphasized conversion and direct religious experience, they perceived 'real religion' as characterized by moral seriousness and sobriety, rather than enthusiasm. Devotion to family life, and a commitment to the moral improvement of society, were the hallmarks of a serious Christian.[45]

This was a shift in the administration of the asylums from previous centuries. The administrators of the asylum believed that employing the patient's body and mind was therapeutically important. The patient played an active role in recovery. Gentle methods replaced physical coercion. Restraints and seclusion were used only when necessary. Moral therapy presupposed that lunatics had a free will and could cooperate with treatment because they were humans rather than beasts.[46] Before becoming mentally ill, many patients enjoyed a vocation and knew its various facets. After the onset of their illness, they were often prevented from working. When they entered an asylum that practiced moral treatment, patients were often allowed to participate in once familiar occupations. The assigned tasks might be very simple depending on the patients' capabilities and fragility. By allowing them to work, the administration satisfied a basic human urge and began the process of restoring self-confi-

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[45]Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum 1792-1917* (London: Routledge, 1992), 29.

[46]Ibid, 28.

dence. Moving patients from their wards during the day to a supervised environment proved to be a successful strategy to begin healing and recovery.

Insane patients were placed in well-organized asylums where everything was predictable. They were not treated as if they had lost their reason; instead, they were expected to control their behavior. Their lives were regulated by a small staff who exercised control over patients by keeping their minds occupied with church, employment, or recreation. The rules required a clergyman to visit the patients and to conduct Sunday worship services; furthermore, patients were to pray daily. Rituals and codes of behavior were used to foster an environment conducive to helping mentally ill patients regain health.

Asylums became enclosed worlds that attempted to recreate some of the habits of the outside world in an artificial environment. Even imbeciles could be taught to do simple, repeatable tasks if given sufficient time, encouragement, and instruction. Patients contributed to the functioning of the asylum community. Whatever their prior occupations or amusements in the outside world was put to use in the safety of the asylum. Edward Jarvis, M.D. who visited county and borough lunatic asylums during the reign of Queen Victoria commented:

> Almost all classes of the insane and demented and mentally defective, have been found to derive advantage from any regular and continuous employment, especially such as requires a series of successive operations, and more particularly if it requires their mental attention to guide their hands in the performance of their work.[47]

Patients contributed as they were able to the functioning of the asylum com-

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[47]Edward Jarvis, *Employment for Patients in the British Lunatic Asylums* (Dorchester, MA: n.p., n.d.), 14.

munity. The aged, feeble, sick, and paralytic, or those too excitable might not be able to work; but they were still treated with kindness and kept clean, fed, and safe. Asylums became a safe microcosm of the external world that was too cold, harsh, and uncaring for the mentally ill to survive.

The non-restraint method removed chains, irons, manacles, and leg cuffs – but it seems that strait-waistcoats were still used for difficult patients when nothing else worked. Alternatively, patients might be tied to a chair or basket to confine their movement. Hanwell Asylum introduced the padded room. The non-restraint system was a complete system of insane patient management. The attendants were expected to be efficient and respectful. If any staff member struck a patient or took a bribe from a patient or family member, he was immediately dismissed. The establishment was well arranged; the diet, liberal; the clothing, clean; and the general atmosphere, cheerful.[48] Restraints never completely disappeared from use. Even York Retreat used them; however, their use became insignificant. Furthermore, as the use of restraints diminished, the use of mild sedatives increased.

Older asylums mainly focused on coercion and controlling the patient. Moral therapy focused on curing the malady and providing care and comfort. The characteristics of moral therapy can be summarized into five essential points. First, lunatics are sick. Second, they deserve human kindness. Third, patients deserve to be treated with dignity. Fourth, the administration's attitude was parental, not paternalistic. Fifth, lunatics could be helped to help themselves through training; nevertheless, many old facilities had not been

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[48]Conolly, *The Treatment of the Insane Without Mechanical Restraints*, 44.

built with sufficient space for employment.

One aspect of moral therapy was work. Statistics show that the goal of many asylums was to induce about two-thirds and often more to engage in some form of labor. Some asylums were able to entice ninety percent to work. The composition of patients in each asylum weighed heavily in the work rate. The number of patients too feeble, aged, sick, paralytic, torpid, or lacking intellect determined how many patients worked.[49] Attendants kept records of the manner and time in which every patient was occupied and sent a copy to the Board of Commissioners in London. Asylums formed a self-contained, controlled environment. Patient labor reduced expenses for ratepayers and dependence on the outside world. Everyone benefited from this system: patients, asylums, government, and ratepayers.

Many influences were used to motivate patients to work: the governing power, the law and the officers, the tact and persuasion of attendants, and the influence of patients who were convalescing. Many lunatics, especially imbeciles or idiots from birth, had never been taught to do any work. Through patience and perseverance, these patients could be taught to perform simple processes by direction and repetition.

Moral treatment was not without its critics. Their hostility is hardly surprising considering the radical departure from previously existing therapies. Moral treatment rejected medical treatment of lunacy and applied a common sense approach.

> If therapeutic agents are cast aside or degraded from their legitimate rank, it will become the duty of the physician to give place to the divine or moralist, whose chosen mission it is to minister

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[49]Ibid., 8.

> to the mind diseased; and of the heads of establishments like this to depute their authority to the well-educated man of the world, who could, I feel assured, conduct an asylum fiscally, and as an intellectual boarding house, a great deal better than any of us.[50]

The vocabulary used to describe the insane was medical: mental illness, patient, treatment, *et cetera*. But non-physicians were going to be allowed to treat lunatics. Reformers were warned to proceed only at "the hazard of great injury to the patients."[51] Despite these efforts to thwart moral treatment by professionals, moral treatment became the *de facto* standard and many medical professionals adopted the approach.

Restraints constituted an effective means of control over lunatics when they became violent or agitated. Manacles attached to the patient's limbs and secured by chains were attached to a wall or the bed where the insane slept. If the patient was out of bed during the day, he might be kept in a straight-waistcoat which kept his upper limbs in bondage. Often patients would be tied to a chair in the open air or a dayroom. All classes of patients were subject to at least one of these restraining methods to keep them under control and unable to harm themselves or others.

Benevolent self-interest drove changes in the use of restraints. Lighter leather restraints replaced chains. This change was generally seen as more humane; nevertheless, restraints were a necessary evil in order to provide safety for patients, staff, and the public. Their use was curtailed; the goal was to use them only as necessary. Some asylums successfully eliminated all use of restraints.

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[50]W. A. F. Browne, *The Moral Treatment of the Insane: A Lecture* (London: Adlard, 1864), 5.

[51]George Man Burrows, *Cursory Remarks on a Bill Now in the House of Peers for Regulating Madhouses* (London: Harding, 1817), 25.

The Lincoln Asylum opened in 1820 and claimed to be the first in London to introduce the non-restraint system. The ideals expressed in the writings of Philippe Pinel and William and Samuel Tuke had been tested for nearly twenty years and had become widely accepted.[52] The asylum only housed fifty lunatics, but as the administration started accepting more patients, many from the poorer classes, its population grew to seventy. With the burgeoning population, the old methods of restraint were reintroduced, albeit, to a lesser degree than earlier. "Light handcuffs were attached to a strong girdle of leather, which went around the waist by a light chain, and gave moderate freedom to the arms and hands."[53] This method, considered a moderate restraint system, was used in most asylums for the insane in the wards where the disorderly and dangerous classes were kept. By 1838, a young physician, Gardiner Hill, modified restraint methods and demonstrated them to be unnecessary. Soon other asylums began to follow the non-restraint method.

> The torpid and the demented, and especially those who were approaching dementia, were taken from the wards to the shops and put to work. These if not willingly, or if not by any active will on their own part in favor of the proposal, yielded to it, at least, with little or no active resistance, and went to the work.[54]

The largest lunatic asylum for paupers was in the County of Middlesex. Located at Hanwell and opened for operation in 1831, it exemplified the utility of nineteenth-century asylums. The residents of the asylums formed a self-contained, self-sufficient community. Members contributed to the social life of the asylum. This was a radical change from enforced isolation and inactivity

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[52]Snow, "The First Advancement," 210.

[53]Ibid., 211.

[54]Jarvis, *Employment for Patients in the British Lunatic Asylums*, 2.

of earlier madhouses and hospitals. In 1837, the patient population comprised about six hundred, mostly incurable, lunatics. About sixty-six percent were employed in useful occupations.[55] Household chores included cooking, brewing, washing, tailoring, spinning twine and wool, making linen and mops, and manufacturing furniture and shoes. Trade in manufactured goods among asylums was common. A quart of beer brewed on the premises was allocated daily to laborers and a pint to other patients.In 1839, John Conolly was also successful in using the new non-restraint methods at Middlesex County Pauper Asylum at Hanwell with nearly a thousand patients. He later published *The Treatment of the Insane without Mechanical Restrains* and *The Construction and Government of Lunatic Asylums and Hospitals for the Insane.*

The new county asylums had cultivatable fields and arable lands surrounding the buildings. Patients grew crops and gardens for food. Pliny Earle, a physician, reported on the conditions of asylums on the continent and England. He describes the pastoral scene that greeted him when he visited Middlesex Asylum in Hanwell just outside London. Earle contrasts the contented state of several women with their earlier confinements. Each had endured lengthy physical restraints. Under moral therapy, their condition and outlook were notably improved.

> On entering the gate...I met...three women rolling the grass in company; one of whom, a merry creature, who clapped her hands at the sight of visitors, had been *chained to her bed for seven years* before she was brought hither, but is likely to give little further trouble henceforth, than that of finding enough for her to do. A very little suffices for the happiness of one on whom seven years of gratuitous misery have been inflicted.... Further on, is another in a quieter state of content, always calling to mind the strawberries and cream Mrs. Ellis set before the inmates on the

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[55]Earle, *A Visit to Thirteen Asylums for the Insane in Europe,* 6.

> lawn last year, and persuading herself that the strawberries could not grow, nor the garden get on, without her, and fiddle-faddling in the sunshine to her own satisfaction, and that of her guardians. This woman had *been in a strait waistcoat for ten years* before she went to Hanwell.[56]

Further in the asylum, Earle documents that he found three or four patients preparing to plant potatoes. Instead of being morose and oppressed, they were singing and amusing each other while cutting potatoes for seed. In the bakery, patients kneaded dough. In the laundry, patients were separating clothes into mounds to be ironed; Earle would not have been surprised to have found them tearing their clothes to shreds instead. On the second story of the building, he found "coteries of straw-plaiters, and basket-makers, and knitters among the women, and saddlers, shoemakers, and tailors among the men."[57] Such peaceful, pastoral scenes starkly contrast the images of Bethlem Hospital. Instead of the harsh discipline and despair experienced at institutions like Bethlem, these patients were content, quiet, manageable, and apparently harmless. They did their work and seemed gratified by the confidence placed in them by the administration. These patients were satisfied by their productive, manual labors. According to Cashman, the Commissioners in Lunacy in 1846 found that "in the county asylums, whenever mechanical restraint had been discarded, there was a proportional improvement in the condition of the patients."[58]

Drawings of stately mansions used to advertise asylums conveyed the impression that lunatics were housed in luxury. This impression may have been true for private patients; paupers were frequently housed in converted

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[56]Ibid., 6-7. Italics in original.

[57]Ibid.

[58]Cashman, *A Proper House: Bedford Lunatic Asylum*, 92.

outbuildings and barns.

> Country mansions and similar large premises, often of imposing appearance, were used, not infrequently, to accommodate lunatics and it was the pauper patients who generally fared worst in such establishments. Whilst the private patients resided in the mansion, often with the proprietor and his family, the paupers, in some instances, were accommodated in the converted stables and outbuildings.[59]

The majority of private licensed houses were premises adapted to accommodate lunatics. The amount of adaptation depended on the initiative of the proprietor and the sum invested. Medical proprietors were unlikely to have large sums of money; so, opportunists of means, but with no other qualifications, were able to exploit the need for asylums.

Part of the reason that county lunatic asylums were constructed was to be able to transfer pauper lunatics from madhouses to these new asylums. Parishes were able to cut costs, especially for chronic patients. The ability to send patients to madhouses depended largely on the wealth of the parish. Stories of madhouse abuses added urgency to move pauper lunatics to county asylums.

Many pauper lunatics who were brought from other private asylums, madhouses, and workhouses were given a chance to have a life closer to normalcy than they previously experienced. Those who had been fettered for years, put in straitjackets, or locked in chaotically loud wards because they were simpletons or mental defectives were now productive and received better care because of moral treatment.

Despite the pastoral scenes used to depict the country asylums, some patients would have received better care at home. John Snow reminisces,

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[59]Parry-Jones, *The Trade in Lunacy*, 57-8.

> It is true, they might have sent him to a madhouse, but there he would certainly not have been better cared for than at home. He would have been under the rod of strangers, and might have been exhibited as a show to those who were curious for strange sights. He might also have been irregularly fed, or improperly clothed to meet the variations of seasons.[60]

Conversely, other patients were better treated in the county asylums than they were at home. Robert Gardener Hill arrived at Lincoln Asylum in 1836 where he abolished physical restraints. He published a letter written by a female patient to a friend.

> The Matron of the Asylum stands at the table, and asks whether we are all satisfied; and if anyone wants more, she orders a nurse to bring it. She wishes to see us all comfortable. We go to bed at eight o'clock; we have nothing to do only to walk in the gardens twice a day, and cards to play, and other sorts of exercises. I never was better off since I left my parents.[61]

Asylum Statistics

John Conolly surveyed superintendents of public asylums between 1843 and 1845. From the responses, he calculated the average number of patients. These data are reproduced in Table 2. The data show that public asylums were much larger than private asylums and that numbers of male and female admissions were almost identical. The table also shows that public asylums opened with increasing frequency. One asylum was opened in the sixteenth century, another in the seventeenth, five in the eighteenth, and twenty-one during the first half of the nineteenth. Only one asylum opened in the first decade of the nineteenth century, eight in the second, six in the third, five in the fourth, and one in the fifth.[62] This growth happened because there was a

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[60]Snow, "The First Advancement," 204.

[61]Jones, *Lunacy, Law, and Conscience 1744 – 1845,* 152.

[62]Conolly, *The Treatment of the Insane Without Mechanical Restraints,* 47.

greater demand for asylums. Industrialization required more hours from their workers, so fewer lunatics could receive care at home. Furthermore, many physicians believed that community safety was better served by placing luna-

TABLE 2. Average Patient Population in Public Asylums

	Date		Admissions		
Name of Asylum	Opened	Report	Males	Females	Total
Bedford	1812	1843	577	524	1,101
Bethlem	1547	1844	2,658	3,643	6,301
Bristol, St. Peter's Hospital	1696	1844	265	316	581
Chatham (Military)	1819	1843	586	22	608
Cheshire	1829	1843	511	386	897
Cornwall	1820	1843	429	329	758
Dorsetshire	1832	1844	202	253	455
Exeter, St. Thomas's Hospital	1801	1844	561	746	1,397
Gloucester	1823	1844	895	804	1,699
Haslar (Naval)	1818	1844	804		807
Kent	1833	1844	439	325	764
Lancaster	1816	1845	2,384	1,912	4,296
Leicester	1837	1844	284	291	575
Lincoln	1820	1844	577	494	1,071
Liverpool	1792	1844	2,418	1,456	3,874
Middlesex (Hanwell)	1831	1845	1,399	1,425	2,824
Norfolk	1814	1844	716	794	1,510
Northampton	1838	1844	373	368	741
Norwich, Bethel Hospital	1713	1844	96	105	201
Nottingham	1812	1845	1,045	808	1853
Oxford, Warneford Asylum	1826	1844			493
St. Luke's	1751	1844	7,130	10,410	17,540
Stafford	1818	1844			3,073
Suffolk	1829	1845	627	620	1,247
Surrey	1841	1843	370	343	713
York	1777	1843			4,032
York Friend's Retreat	1796	1843	336	379	715
Yorkshire, West Riding	1818	1843	1,682	1,657	3,339
Totals			27,457	28,410	63,465

tics in asylums rather than allowing them to remain at home. There was also

TABLE 3. Metropolitan Licensed Houses (4 May 1818)

Counties and Number of Licensed Houses	Names of Persons to Who Licenses are Granted	Number of Patients Confined to Each House		
		Male	Female	Total
Middlesex				
3 at Hoxton	William Burrow, Esq.	61	57	118
6 at Hoxton	Sir Jonathan Miles	199	149	348
1 at Hoxton	Thomas Warburton, Esq.	47	31	78
1 at Blacklands, Chelsea	Mary Bastable	14	11	25
1 at King's Road, Chelsea	Mary Bradbury		4	4
1 at King's Road, Chelsea	George Man Burrows, Esq.	4	6	10
1 at King's Road, Chelsea	Jane Jones		11	11
1 at Church Street, Chelsea	William Press, Esq.	1	2	3
1 at Little Chelsea	Elizabeth Reedford	3	7	10
1 at Beaufort Row	Robert Salmon, Esq.	5	3	8
1 at Lower Street, Islington	James Annandale	13	7	20
1 at Kingsland	William Bignal, Esq.	1	2	3
1 at Kensington Gore	Anna Maria Briand	9	7	16
1 at London Lane, Hackney	Samuel Fox, Esq.	11	14	25
1 at Hackney	George Rees, Esq., M.D.	10	9	19
1 at Turnham Green	John Thompson Jackson, Esq.	2	1	3
1 at Brook Green Hammersmith	Thomas Maynard Knight, Esq.	2	5	7
1 at Paddington	William Langdon, Esq.		3	3
1 at Somer's Place, Somers-town		5	1	6
1 at Winchmore Hill	Phoebe Richardson		4	4
1 at Hillingdon, near Uxbridge	James Stilwell, Esq.	2	3	5
1 at Walham Green, Fulham	Edward Talfourd, Esq.		17	17
3 at Bethnal Green	Rhodes, Esq.	146	169	315
3 at Bethnal Green	Talbot, Esq.	241	241	482
Surrey				
1 at Buildford, called Leepale House	Thomas Hill, Esq.	1	1	2
1 at Chertsey, called Weston House	Thomas Hill, Esq.		3	3
1 at Frimley	Robert Stracey Irish, Esq.	2	1	3
1 at Thorpe, called Great Forster	Charles Summers, Esq.	12	6	18
1 at Lower Tooting	Ann Sandiford	2	5	7

more chance for a cure if lunatics were placed in asylums early rather than remaining at home.

Analysis of the data in Table 3 shows that 54.8% of the licensed houses in Middlesex and Surrey served ten or fewer lunatics, 74.2% served twenty or fewer, and 80.7% served thirty or fewer. Only six served fifty or more lunatics. The pattern was to have many small private houses and only a few large ones. Surprisingly, the two largest private houses served 51.1% of all the lunatics in the Middlesex and Surrey private houses.[63]

The sizes of madhouses varied dramatically. A couple of madhouses could house over half the lunatic population in a district. The majority were small-scale operations with fewer than ten lunatics, and seventy-five percent contained fewer then twenty. Large licensed houses with more than three hundred lunatics were the exception rather than the rule, although the majority of the patients were housed in these large institutions.

Workhouses

Workhouses were not a desirable place to live for able-bodied laborers; how much worse they must have been to the mentally ill! The condition of paupers in workhouses is contrasted with the homeless by Charles Dickens in *Barnaby Rudge.*

> To be shelterless and alone in the open country, hearing the wind moan and watching for day through the whole long weary night; to listen to the falling rain, and crouch for warmth beneath the lee of some old barn or rick, or in the hollow of a tree; are dismal things—but not so dismal as the wandering up and down where shelter is, and beds and sleepers are by thousands; a houseless rejected creature.[64]

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[63]Granville, *The Care and Cure of the Insane,* 33.

[64]Dickens, *Barnaby Rudge;* Internet.

Prior to the 1834 Poor Law, some workhouses had accommodations for the insane. The House of Industry of the Flegg, in Norfolk, was constructed between 1775 and 1777 with separate accommodations for lunatics.[65] St. Peter's Workhouse in Bristol also housed lunatics and provided weekly doctor visits.[66]

Before 1834, the insane poor were mixed with the general population of the workhouses. Housing pauper lunatics in workhouses cost less than maintaining them in asylums. Because guardians answered to the electorate, it was to their advantage to minimize the rates. The Poor Law Amendment Act of 1834 gave the Board of Guardians the authority to request all workhouses to provide special wards for the mentally sick. Not all workhouses could afford to segregate the insane from the general population in newly built wards, special areas, or rooms; for example, in many rural areas the small number of insane in the workhouses could not justify expensive separate buildings.

The presence of lunatics among the general poorhouse population "inexpressibly increased the wretchedness of other inmates."[67] Lunatics made queer noises, laughed maniacally, inanely teased, and practiced disgusting habits. Efforts by attendants to control lunatics could exacerbate their obnoxious behaviors to the discomfort and embarrassment of the aged, infirm, and paupers who had the misfortune to be nearby. On the other hand, conditions could not have been pleasant for lunatics either. They had no solitude and

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[65]Anne Digby, *Pauper Palaces* (London: Routledge, 1978), 37.

[66]Porter, *Mind-Forg'd Manacles,* 18. The use of "inmate" in the quotation denotes someone who is confined to an institution such as a prison or hospital.

[67]Glover, *The Retreat York,* 95.

could be the objects of scorn and laughter. Children could mock them. Moral or psychological treatments were unlikely. Patients cared for other residents. "Most of the nursing was done by elderly and illiterate pauper inmates of the 'Sairey Gamp' type." [68] By 1866, 142 paid non-pauper nurses, most without any hospital training, cared for 21,000 sick and aged patients in the London.[69] Out of necessity, difficult or dangerous patients would be restrained for the general safety.

Many insane paupers were forced to stay in the parish workhouses because no other places could be found for them. By 1828, it was estimated that 9,000 lunatics and idiots were living in workhouses.[70] If an opening arose in a lunatic asylum, there was not a guarantee that the poor lunatic would be accepted; furthermore, many workhouse physicians would keep only those who presented little or no difficulty. If residents became violent, the 1834 law gave the workhouse only fourteen days to transfer their violent patient.[71] Notwithstanding this legal requirement, the lunatic might not be transferred because of the difficulty in finding an institution willing and able to accept him. Financial factors could play a critical role in the placement decision.

> The Parish Overseers, discovering that the cost of maintenance, (at times as low as 6/6d. per week) exceeded the cost of maintaining the patient in the workhouse were reluctant to send patients into the asylum until they became unmanageable. This reluctance caused great hardship, and much human misery, and in

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[68]Gwendoline M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board 1867 – 1930* (Berkeley: University of California, 1971), 3.

[69]PP 1867-68, lx, (H/C 4), Appendix, 24.

[70]Jones, *Lunacy, Law, and Conscience*, 161.

[71]Laws, Statutes, etc., *An Act to Amend an Act Passed in the Ninth Year of Her Majesty, for the Regulation of the Care and Treatment of Lunatics*, 1853, 16 & 17 Vict. c. 96.

addition substantially reduced the chances of a cure in many cases.[72]

A change in attitude toward insanity took place between the beginning of the century and the last half of the century. Lunacy was not perceived as a divine curse or demonic possession; rather, it was a treatable medical condition. Asylums did a better job of attracting families and convincing them that their loved ones would be well-treated: i.e., without coercion and physical restraint. Rather than keeping lunatics hidden at home, families realized that mentally ill family members could safely be placed in asylums for care. Consequently, the demand for asylum care outstripped the supply. The population of chronic patients expanded because patient health care and sanitary conditions improved: life expectancy increased, placing additional demands for a limited number of beds.

Heavy demand for limited asylum resources necessitated that lunatics be diverted to workhouses. Urbanization and industrialization created conditions that were too harsh for lunatics to live in unsheltered environments. Furthermore, restrictions placed on outdoor relief made their lives difficult and forced lunatics into the workhouses to receive relief. A lack of sufficient accommodations made placement in workhouses expedient and necessary.[73]

The evidence for the presence of lunatics in the workhouses is substantial, although the level of detail is not as great as one would like. The evidence

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[72]Ashworth, *Stanley Royd Hospital,* 11.

[73]Henry Charles Burdett, *Hospitals and Asylums of the World. Their Origin, History, Construction, Administration, Management, and Legislation: With Plans of the Chief Medical Institutions Accurately Drawn to a Uniform Scale in Addition to Those of all the Hospitals of London in the Jubilee of Queen Victoria's Reign,* vol. 3 (London: J. & A. Churchill, 1893), 151.

includes eyewitness accounts, the 1838 changes to the New Poor Law that allowed the non-dangerous insane to reside in workhouses, transinstitutionalization, [74] and annual reports to Poor Law Commissioners and the Poor Law Board.

Eyewitness Accounts

Accounts by eyewitness are varied. They describe abuses, poor housing conditions, and mistreatment of lunatics in workhouses. Henry Alexander, a banker with an interest in lunacy reform, developed extensive evidence about lunatics in workhouses. During business trips he visited and documented the conditions under which lunatics were confined in workhouses. Alexander's initial efforts to visit the Tavistock Workhouse were initially rebuffed. He was reluctantly shown lunatic living quarters after being warned that they were uninhabitable although they had been washed earlier in the day.

> I never smelt such a stench in my life, and it was so bad, that a friend who went with me [into the first cell] said he could not enter the other. After having entered one, I said I would go into the other; that if they could survive the night, I could at least inspect them.... The stench was so great I almost suffocated; and for hours after, if I ate anything, I still retained the same smell; I could not get rid of it; and it should be remembered that these cells had been washed out that morning, and had been opened some hours previous.[75]

In February 1849, the poor law inspector of Charity Hall reported: "I have this day inspected the rooms and yards dedicated to the insane, and, consider it

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[74]*Transinstitutionalization* is a neologism coined to describe the transfer of patients between one institution and another; an example is the late twentieth-century American practice of deinstitutionalizing state hospitals and moving these patients onto the streets and into the prisons and jails. Initial exposure to the term was found in papers by Carla Jacobs, California Alliance for the Mentally Ill.

[75]Andrew T. Scull, *Museums of Madness*, 79-80.

my duty to state that they are wholly unfit for the purpose."[76]

1838 Changes to the New Poor Law

The 1834 Poor Law provided that dangerous insane could reside in workhouses for no more than fourteen days.[77] By implication, though not explicit in the law, non-dangerous lunatics could be housed in workhouses. In 1838, Poor Law Commissioners sanctioned inclusion of lunatic wards in large workhouses.[78] Growing numbers of pauper lunatics were entering the workhouses by the beginning of the nineteenth century. Many had unlicensed lunatic wards set aside within the workhouse. Some workhouse directors sought licenses to set aside large sections for their lunatic population. The Oswestry and Shrewsbury houses of industry were licensed in 1821; by 1831, part of the Carisbrooke poorhouse, and, by 1837, the workhouse at Stoke Damerel, had also been licensed.[79] By allowing lunatics to be accommodated in workhouses, the government recognized the existing practice and gave it approval. Lunatics in workhouses received only custodial care. In 1842, the practice of housing non-dangerous lunatics in workhouses received legislative approval.[80] In 1859, ten percent of the workhouses had lunatic wards.[81] By 1865, fifteen per-

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[76]Bickford, *The Private Lunatic Asylums of the East Riding,* 10.

[77]*An Act for the Amendment and Better Administration of the Laws Relating to the Poor in England and Wales*, 1834, 4/5 William IV, c. 76, s. 45.

[78]Hodgkinson, *The Origins of the National Health Service,* 179-180.

[79]Parry-Jones, *The Trade in Lunacy,* 57.

[80]*Eighth Annual Report of the Poor Law Commissioners*, 1842, PP 1842 [359] xix 1 111.

[81]*Supplement to the Twelfth Annual Report of the Commissioners in Lunacy*, 1859, PP 1859 s. 1 (228) ix 1 9.

cent of the workhouses had lunatic wards.[82] In 1867, the Metropolitan Poor Act required that workhouses for the insane be constructed.

Housing lunatics in workhouses proved financially advantageous. Edwin Chadwick, a Benthamite, and many of his supporters bitterly opposed the humanistic approach to social problems. Chadwick was effectively the Secretary of the Poor Law Commission between 1838 and 1847. He believed that custodial care of the insane in workhouses was justifiable—only the violent ones should be sent to asylums. This saved the Board of Guardians money because maintenance at an asylum was more expensive. Chadwick argued that if asylums were not curative then it did not matter where the insane were detained.

Clarification of the function of workhouse and asylum was required. Pauper lunatics who functioned well in an asylum setting probably could have received custodial care in a workhouse. Conversely, pauper lunatics in workhouses who did not function well probably could have been better served in an asylum. Confusion about the respective roles of workhouses and asylums resulted in tension among administrators and a failure to deliver appropriate services to lunatics.

> Dr. Boyd, the parish doctor of St. Marylebone ... pointed out that there were seventy-nine patients from that parish in the Middlesex Asylum at Hanwell, all of whom were incurable save four. Among them were twenty-two quiet chronic cases—patients who would be capable of living the normal restricted life of the workhouse without causing alarm or annoyance to the other inmates. At the same time, there were many patients in urgent need of treatment who remained in the Marylebone workhouse because there was no accommodation for them in Hanwell.[83]

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[82]David Mellett, *The Prerogative of Asylumdom*, 156.

[83]Jones, *Lunacy, Law, and Conscience 1744 – 1845*, 167.

Lunatics moved in and out of workhouses. When lunatics in workhouses became unruly and unmanageable, they were moved to asylums. After they sufficiently recovered, they were returned. Peter Bartlett estimates that twenty-five percent of the workhouse residents were lunatics.[84] The *per diem* cost of sending a lunatic to an asylum was more than of sending him to a workhouse; however, in the long term, asylum costs could result in lower expenses if the patient were cured. Dr. William Charles Ellis, the first director of Stanley Royd Hospital, discussed the need for reform in his annual reports. In 1828, he wrote that it was cheaper to treat and possibly cure a patient at a slightly higher weekly cost than it was to pay a smaller weekly rate indefinitely.

> Apparently, the being able to admit the patients at a rate not exceeding the sum which they would cost in the Workhouse is the only method of inducing some of the Overseers to send them in the early stages of the disease.[85]

The inability of Ellis to admit so many patients and to cure and discharge the patients quickly resulted in unnecessary suffering and a need for additional accommodations. This inability to treat patients quickly created a backlog; in other words, the demand for services exceeded the capacity of the asylums. Authorities frequently needed to choose between these two alternatives, asylums and workhouses. Because workhouses, houses of corrections, and jails were designed as punitive institutions, Dr. Battie, first physician at St. Luke's Hospital, wrote that these institutions were inappropriate for lunatics; instead, lunatics should be placed in asylums where the objectives were cura-

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[84]Bartlett, "The Poor Law of Lunacy," 62-63.

[85]Ashworth, *Stanley Royd Hospital,* 11.

tive.[86] Patients could be moved between institutions as room became available and for institutional convenience rather than patient convenience.

Reports

Reports show that lunatics were confined to workhouses before administrators received explicit statutory permission in 1838 and 1842. Case reports can be found in which a pauper patient wanted to be moved into an asylum from the community; likewise, case reports show that lunatics in workhouses wanted to be transferred to asylums. These patients could become agitated until their requests for transfer was effected. Peter Bartlett cites several examples. Robert Capenhurst attempted suicide several times to force workhouse officials to transfer him to an asylum. William Thompson was a disruptive pauper confined to a workhouse. Within hours of admission to an asylum, he became peaceful and began to do useful work.[87]

In 1827, Lord Robert Seymour argued for the construction of a county asylum to serve Middlesex based on estimates that twelve hundred lunatics resided in country workhouses and madhouses. He believed that a county facility would better serve the needs of lunatics at a lower cost to the ratepayers.[88]

> From 1842 to 1890, a steady twenty-five per cent of poor persons identified as insane were institutionalized (*sic*) in the workhouse, an increase from 3,829 in 1844 to 17,825 in 1890. Many of these

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[86]Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796 – 1914* (Cambridge: Cambridge University, 1985), 4.

[87]Peter Bartlett, "The Asylum, the Workhouse, and the Voice of the Insane Poor in 19th-Century England," to be published in *International Journal of Law and Psychiatry*. Personal correspondence.

[88]John Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (1847; London: Dawsons of Pall Mall, 1968), 9.

> people were housed with the general workhouse population. However by mid-century, they were increasingly classified within the workhouse environment itself, and special wards were built to house them. In 1859, the Lunacy Commissioners reported that about one tenth of the workhouses in England and Wales had such wards. By 1865, 104 of the 688 workhouses in England and Wales had these dedicated wards.[89]

Foucault's Lepers

Foucault asserts that the insane were segregated from society in the same way that lepers were excluded from communities during the Middle Ages. The disappearance of lepers at the end of the Middle Ages left a void that the insane filled in the exclusionary structure of society.

> What doubtless remained longer than leprosy, and would persist when the lazar houses had been empty for years, were the values and images attached to the figure of the leper as well as the meaning of his exclusion, the social importance of that insistent and fearful figure which was not driven off without first being inscribed within a sacred circle.[90]

The Renaissance freed the voices of the insane — a voice the bourgeoisie needed to silence. The leper houses were used to confine the insane and the poor. Eighteenth- and nineteenth-century society made the insane disappear and silenced them by confining them in madhouses, asylums, workhouses, poorhouses, hospitals, and jails. Moral therapy was particularly insidious because it attacked and altered the minds of lunatics. Lunatics were less free because not only their bodies but also their minds were subject to treatment.

At first glance, Foucault's attractive thesis offers a coherent construction of isolated events; however, it is the treatment of *isolated events* that is the downfall of Foucault's thesis. The overarching concerns of all parties—reformers, utilitarians, politicians, evangelicals, physicians—were protection

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[89]Bartlett, "The Poor Law of Lunacy," 62-3.

[90]Foucault, *Madness and Civilization*, 6.

and care. Protection took two distinct directions: safeguarding the patient from himself and from members of society who might exploit or harm the insane, and guarding society from the violence of unpredictable lunatics. Humane care and other considerations were subservient to the goal of protecting everyone. Protection constituted the highest good. Whether a lunatic was allowed to roam the countryside, permitted to remain at home, or confined in workhouses, poorhouses, jails, hospitals and infirmaries, or asylums depended on the degree of protection and care that were required. In addition to protection and care, funding to pay for services and capacity of facilities to offer those services formed the core of the debate. These issues, protection and humane care, are central to the thesis that upper-class and bourgeois benevolent self-interest motivated social policy related to madness.

Foucault's charges that the mutual goal of all the parties was to segregate and silence lunatics are specious. There is no evidence that any of the parties wanted to do this. If anything, the emerging system permitted the insane to remain visible and functionally related to the social structure insofar as they did not constitute a danger to themselves or society. Furthermore, cure and hope were offered to the insane. Sequestration of the acutely insane was as much therapeutic as it was protective.

Szasz and Rosen argue closely related views. They are cynical toward the medical profession. Szasz makes the medical profession the creator of mental illness to line their pockets. He argues that the medical profession created lunacy to garner and enhance their power and control over society. Rosen maintains that the structures put in place for the insane came about because of a conspiracy between the medical profession and the government. Many individuals profited from the new institutions created for lunatics. Many in

the community profited from these institutions: craftsmen, manufacturers, and merchants. Physicians, however, were not overrepresented among the profiteers. Physicians were required to cover the expenses for medications that they administered to asylum patients. Furthermore, many of asylum superintendents were landed gentry, not physicians, and were hired by country magistrates. It is interesting to note that John Conolly, a leading reformer and physician, did not acquire great wealth from the asylum system. He died penniless. Therefore, although some physicians profited from the asylum system, most had to maintain their outside practices to supplement their incomes. Szasz and Rosen overstate the evidence.

Foucault, Rosen, and Szasz offer an interesting interpretation of the historical record. Their views represent a reconstruction of history that takes isolated facts and stitches them together into a new tapestry; unfortunately, the stitches that connect the patches are not supported by the record itself.

Summary

The accommodations for the insane poor varied. The focus of each establishment was to secure and control patients while they were ill. Some places created therapeutic environments, and others were merely custodial. Sometimes only basic needs were supplied: food, shelter, and clothing. Others provided more extensive services and care. The ability to pay often determined the level of the services delivered. People from all walks of life and socioeconomic status were served by institutions for the insane. Stereotypes were slowly eroding. With the creation of county asylums that were funded at public expense, the insane poor began to receive more humane and caring treatment, although workhouses continued to give custodial care to the

chronic and less bothersome patients. The creation of county asylums marked a shift in the level of mental health care delivered to pauper lunatics. Where the private sector failed to provide adequate care and supervision for pauper lunatics, the public sector began to deliver with county asylums. Although conflicting bureaucracies made delivery of mental health services inconsistent, upper-class and bourgeois benevolent self-interest underlaid treatment of the mentally ill.

CONCLUSION

In seeking the best explanation concerning the treatment of the insane between 1808 and 1865, a model of inference common to all inductive reasoning is employed: inference to the best explanation. From a pool of interpretive options, the option that best accounts for why the evidence is as it is and why it is not otherwise is selected from the competing explanations. This methodology applies to history as much as it does to science. Scientists test theories by designing and performing experiments; historians test historical theories by testing how well they elucidate the evidence.[1]

The available historical evidence has been laid out in each of the previous chapters. Chapter 1 examined the phenomena of mental illness from the perspectives of medical practitioners and, to a limited extent, philosophers from the fourth century B.C. through the middle of the eighteenth century. Chapter 2 described legislation that affected lunatics in England from 1324 through 1862 with an emphasis on the period between 1808 and 1862. Chapter 3 described where the insane could be found: wandering the countryside, and locked away at home, infirmaries, hospitals, madhouses and asylums, workhouses, and poorhouses. It also described the medical treatments used by practitioners to ameliorate and treat insanity.

The hypothesis of this thesis is stated in the introduction: bourgeois and upper class benevolent self-interest produced reforms in the poor law institutions that served pauper lunatics between 1808 and 1862. The tension

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[1]This conclusion closely follows the methodology suggested by C. Behan McCullagh, *Justifying Historical Descriptions* (Cambridge: Cambridge University, 1984).

between charity on the one hand and self-advancement and selfishness on the other is observed throughout the period of the study. The Earl of Shaftesbury was motivated to improve the lot of the insane for sixty years because he had an epileptic son. Many of the reforms were driven by religious considerations. Benevolence is rewarded in eternity by God and in the present by higher social status in a church or sect. William Tukes's impact on the treatment of the insane is illustrative. Abusive treatment of lunatics and an insane Quaker woman's death in the York Asylum under suspicious circumstances motivated him. He acted within his Quaker beliefs. York Retreat brought him national honor and renown; nevertheless, he sought to honor God and to conform to his religious beliefs. Tuke's religion formed the basis for moral treatment. Pinel's moral treatment was secular and was grounded in Jean-Jacques Rousseau's *The Social Contract*. Pinel's approach to treatment was thus built on the rights of man, Tuke's on the image of God imprinted on mankind. Starting from diametrically opposing positions, both arrived at the same treatment for the mentally ill. The utilitarians sought uniformity, consistency, and order. Although they were not an overtly benevolent group, they sought to impose organization and order on society and reforms. Chadwick was involved in many reforms: clean water, efficient sewage systems in London, epidemic and disease abatement, and lunacy and poor law reforms. This thesis shows that benevolent self-interest took three forms: legal, institutional, and therapeutic. The foremost benevolent self-interest was protection. Lunatics needed to be guarded from themselves and a society with malevolent people. Communities required security and safety. Citizens needed protection from the erratic behavior of madmen.

The treatment of the insane improved in the nineteenth century. Gov-

ernment action that allowed counties to build asylums in 1808 opened the door to far reaching reforms that benefited insane paupers. It also began a process of centralized control and regulation that alleviated and reformed the care and treatment of lunatics. Because county asylums were not compulsory, fewer than eighteen county asylums were constructed by 1844. A continuing public outcry regarding inadequate care that insane paupers were receiving in madhouses and workhouses persuaded many reformers to investigate the horrid conditions in which insane paupers were warehoused. Reports provided evidence to Select Committees that insufficient work had been performed to solve the problems of the lunatic paupers. A public crisis existed that was caused by inadequate care, unenforced regulations, injustices at the hands of parish officers, and pecuniary concerns. These caused government to fail its neediest and most helpless citizens. The act of 1845 that made county asylums mandatory resulted in better care for these unfortunate people.

If humanitarian reforms toward the insane had not been implemented with other social reforms of the times, this time period would have been an even greater "black mark" against the upper class and emerging bourgeoisie. Victorian social morality required that all people in society be treated fairly and humanely. This morality stemmed from their philosophical and religious beliefs. Porter observes, "If wealth was to enjoy security, it must wear a human face."[2] Many reformers may have gained social status. Willis, for example, was given a generous pension after treating King George III. Whatever the motivation, the process of reform was slow, and the local authorities

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[2]Roy Porter, *Disease, Medicine and Society in England 1550-1860* (New York: MacMillan, 1967), 39. (Paraphrase).

were not always anxious for the central government to dictate laws and standardize care. It took half a century of investigation, debate, and discussion in Parliament starting in 1807 for the asylum system to become established and state-supported. The progress slowly took away local control and placed it in the hands of a centralized authority. The system in its infancy was not efficient. Many different authorities tried to exercised administrative control over the insane until the system was coalesced in 1862.

Rival hypotheses offered by Foucault, Rosen, Szasz, and Scull have been shown to be deficient. They fail to explain adequately and account sufficiently for human behavior, laws, and humanitarian philosophies and religious beliefs. They impose a cynical late twentieth-century philosophical view on the interpretation of history. They ignore or casually dismiss evidence that does not conform with their preconceived notions. They are criticized in the previous chapters. As Gerald Grob said, "What troubles me, however, is the quality of the historical data used in legitimizing or opposing particular policies."[3] One of their fundamental errors is the confusion of side-effects with intentions. The intention of the reformers and government was to control madmen so that everyone would be safe; unfortunately, too often the side effects were squalor and inhumane conditions that required reform.

Foucault's historiography of mental illness was wrong. The fact that severe mental illness has existed throughout history has numerous implications. From ancient times, lunacy has been rejected by society. It has been an

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[3]Gerald N. Grob, "Rediscovering Asylums: The Unhistorical History of the Mental Hospital," in *The Therapeutic Revolution: Essays in the Social History of American Medicine*, ed. Morris J. Vogel and Charles E. Rosenberg (Philadelphia: University of Pennsylvania, 1979), 135.

aberration from normalcy. This contradicts Foucault who held that at some time reason and unreason, rationalism and madness peacefully coexisted in dialog. It also argues against those who claim that this tension is a modern phenomenon to oppress people or to generate profits. If severe mental illnesses existed in the past, they cannot be new or chronic with industrialization or urbanization. This, in turn, contradicts the views of Michel Foucault, George Rosen, Thomas Szasz, and Andrew Scull. Their positions are based on *a priori* interpretations of the historical record. The phenomena of severe mental illness need to be viewed in historical context and the progress of science. Care and treatment depended on world-view and scientific understanding. Lunatics could be ejected from society, restrained at home, or imprisoned. They could be viewed as possessed by external powers, diseased, morally deficient, dangerous, or defective. Madness and lunacy were not labels created for social misfits or for oppression. Nor were madmen accorded an elevated status from which they plummeted when public policy confined the insane in institutions. Madness and lunacy were categories used to label, understand, and communicate bizarre idiosyncratic phenomena.

The hypothesis that benevolent self-interest controlled the reforms that occurred between 1808 and 1862 is more plausible than the radical alternatives. It is less easily falsified by the historical data than interpretations of Foucault and his followers. The view proposed in this thesis, benevolent self-interest drove reforms, limits the assumptions that must be made to interpret the past. It assumes that an understanding of the past can be developed in light of technical research and limits the imposition of a particular philosophical or political agenda. The past is understood within its intellectual, philosophical, religious, and historical context. This thesis requires an

understanding of the advancement of technology, science, and medicine. Furthermore, it imposes fewer suppositions about the historical record than rival hypotheses, which must assume more from the record. In addition, the hypothesis advanced in this thesis is contradicted by fewer generally accepted beliefs. This author believes that this thesis presents a more coherent view of the record than Foucault's, Rosen's, Szasz's, and Scull's competing hypotheses. Finally, the thesis that upper class and bourgeois benevolent self-interest determined public policy toward lunatics between 1808 and 1862 exceeds the rival hypotheses so much that there is little chance that an alternative is true.

Supplemental Concluding Observations

In addition to the central thesis that the system of care for pauper lunatics developed as a result of bourgeois and upper class benevolent self-interest, several other observations cannot be overlooked. History is like a stream that has a natural flow. When the stream is studied, currents and eddies that interact with the main flow are discovered. Several currents and eddies were found that interacted with the main flow of the thesis. First, central control over the issue of pauper lunatics was required. This is necessary to prevent abuses and to protect the insane and society. Local government frequently lacked the means and the motivation to care for pauper lunatics. Second, a new social psychology developed by the nineteenth century. The insane ceased to be treated like dumb animals and began to be cared for like poor, sick people. Third, a new, natural science developed. The insane began to be viewed as having a "mental illness," though the phrase remained to be coined, caused by a biological change. Optimism that science would prevail in curing insanity was ascendant. Finally, historians too frequently project anachronistic ideas

on the past. They reinterpret history to the detriment of the key figures. Foucault, for example, does this with William Tuke by attributing sinister motives to moral therapy at York Retreat. His postmodern philosophy believes that moral therapy moved lunacy into a moral sphere from a medical one. This viewpoint misreads what moral therapy was about. It was first and foremost about treating lunatics morally, with the dignity and respect that should be accorded any human being. Each of these observations grows directly out of the material examined to support the thesis and is worthy of additional research.

Earlier developments in science, technology, and medicine affect future developments. One generation builds on an earlier generations' insights and applications. Scientific and philosophical developments and conclusions affect how medicine is practiced in each generation. Many examples from the history of science illustrate its progressive nature. Gregor Johann Mendel (1822 – 1884), the father of genetics, experimented by crossing pollinating peas in a small monastery garden to discover the mathematics of genetics. Over a century later, James Watson and Francis Crick formulated a molecular model of DNA for which they received the Nobel Prize in Medicine in 1962. Imaging technology illustrates the progressive nature of science. In 1913, William D. Coolidge invented the X-ray tube. Brain imaging techniques using primitive X-ray machines soon followed. Newer brain imaging techniques allow for the observation of brain structures and metabolism: CT scan, PET, SPECT, MRI, and fMRI. Studies of the electrical activity in different regions of the brain have also advanced over time. Hans Berger developed an electroencephalograph in 1929 to measure the brain's electrical activity. Evoked potentials, or more precisely event-related potentials, are variations in the brains electrical

activity that occur in response to specific stimuli. Picton and his colleagues described these waveforms in 1974,[4] and their significance for understanding psychoses is part of the ongoing scientific investigation of the severe mental illnesses. Similarly, scientific and medical understanding of severe mental illnesses has progressed far beyond what was available to the anti-psychiatrists.

Many of the techniques used to understand severe mental illnesses have only become available within the last thirty years. Foucault and Szasz were influenced by the optimism and civil rights movements of their time. Their *a priori* interpretation of history does not conform to events, discoveries, and literature. They did not have the wealth of scientific information available when they wrote to know that the severe mental illnesses are neurobiological in origin rather than simply psychic. The demise of Freudian psychoanalysis and the ascendancy of biological psychiatry began in the mid-1950's and ended between 1970 and 1980.[5] The delivery of efficacious treatments is a relatively recent phenomenon. The information that caused this paradigm shift became easily accessible after the mid-1980's. Furthermore, the American civil rights movement of the 1950's and 1960's required a new oppressed class to liberate. After African-Americans no longer required extensive use of civil rights activists, a vacuum for their litigation services existed. Civil rights lawyers then turned to another group for their services: the severely mentally ill who were involuntarily confined to state hospitals. In many states, the mentally ill who were confined to institutions were denied the right to vote or marry or were

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[4]T. W. Picton, *et al.*, "Human Auditory Evoked Potentials," *Clinical Neurophysiology* 36 (1974): 179-190.

[5]Hale, *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans, 1917 – 1985*, 302-303.

subjected to involuntary medical procedures like lobotomies and sterilization.[6] The lawyers rode in like cowboys with their white hats to liberate the oppressed inhabitants of state hospitals. It did not matter that in giving patients the right to vote and marry, lawyers took away treatment. For their philosophical underpinning, the civil rights attorneys adopted the writings of Foucault and others who uncritically followed him.

The most generous interpretation of Foucault and his followers is that they were a product of their time and erred by imposing their postmodern philosophy and socioeconomic views on the history of lunacy. Anti-establishment paranoia resulted in a forced historical revision of madness. The most cynical interpretation is that they distorted their historiography for the sake of novelty. Because Foucault died in 1984, he may have erred because of a lack of adequate information. Szasz, despite available evidence, continues to deny that severe mental illnesses even exist. Szasz and Torrey debated each other in an academic forum after much of the evidence for a biological origin for the severe mental illnesses was widely available.[7]

Areas For Further Research

Socioeconomic status too often determined the level of services delivered to lunatics. This thesis illustrates that the system of care for the insane

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[6]Rael Jean Isaac and Virginia C. Armat, *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (New York: Free Press, 1990), 109-124; E. Fuller Torrey, *Nowhere To Go*, 31-34, 157-159.

[7]Richard E. Vatz, "Serious Mental Illness: What to do about it," debate between E. Fuller Torrey and Thomas Szasz at Towson State University in Maryland, 30 October 1996. Tapes available from Richard E. Vatz, Department of Speech and Mass Communication, Towson State University, Van Bokkelen Hall, Towson, MD 21252.

was prone to abuse. The affluent received a superior level of service because they were able to afford it. Because pauper lunatics could not pay, they were often ill-treated. Parish paupers were nicknamed "PP." On the rare occasions that paupers shared the same facilities with the affluent, socioeconomic status determined the level of care. The quarters of the poor were crowded, and food was inferior. Lunatics from affluent families enjoyed more spacious quarters and better food. The lifestyles of lunatics were compatible with their earlier manner of life. Paupers were used to squalor, so they continued to live in squalor. The affluent were accustomed to clean accommodations, so they were separated from the "Augean Stables." The public and care providers believed they had no obligation to improve a lunatic's lot in life. The socioeconomic status of pauper lunatics lagged behind that of the poor working in the community. As economic prosperity trickled down to the working poor, laborers joined the emerging middle class in industrialized, urbanized England. It was only a matter of time before pauper lunatics began to experience some of the economic prosperity experienced by the working poor who lived outside the hospitals, asylums, poorhouses, and workhouses. The socioeconomic conditions of the poor in 1862 improved from those in 1808; likewise, the services delivered to pauper lunatics improved during this time. The relationship between socioeconomic status and the level of care delivered to the insane is an area that requires future investigation.

Detailed studies of patients would aid modern understanding of conditions, diagnoses, therapies, relapses, etc. Some scholars believe that severe mental illnesses are a result of socioeconomic factors. Others believe that the prevalence of severe mental illness has changed over time. Disorders like schizophrenia and manic-depression may be more common at the beginning of

the twenty-first century than during the nineteenth century. Insight into the prevalence and manifestation of insanity would shed light on etiology. Select committee and inspection reports are fascinating to read and analyze; nevertheless, they are sparse and conform to the minimum legal requirements. At least two types of retrospective studies are required: longitudinal and sequential. Longitudinal studies follow patients over a long time — years or decades. Sequential or random studies analyze a group of patients who are admitted during a short time interval. This type of field work would show relapse rates, effectiveness of treatment and government policies, and much more. Sequential studies select the first 100 consecutively admitted patients who meet study requirements. Many of the necessary records exist at institutions like the Wellcome Institute; however, access is limited to researchers with appropriate grants. These studies would be of immense use to modern medical researchers.

Finally, the thesis that upper-class and bourgeois benevolent self-interest determined public policy toward lunatics was applied to a narrow period, 1808 to 1867. It may, in fact, be more generally applicable to social issues facing governments in other times, cultures, and economic systems. Other scholars should apply the principle of benevolent self-interest in other contexts to determine its limits and applicability.

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